

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NEARLY NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14585							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nancy Kelly Ailstock										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 23 1981		2b. HOUR M 11 P M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 24 59		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 21		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 23 1981		2d. HOUR P M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.							
10. CITY OR TOWN OF DEATH Catonsville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastbound ramp to Rt 70 from Rt 695				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Order Editor		12b. KIND OF BUSINESS OR INDUSTRY Johnson Wax							
USUAL RESIDENCE, (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.										13b. CITY OR TOWN Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5906 Franklin Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Howard W. Ailstock										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carole Moody							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-70-1028				17. INFORMANT ADDRESS J.T. Morriss & Son, Box 1168, Petersburg, Va.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple visceral and skeletal injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 10:16 a.m. 6 23 1981				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in vehicle/vehicle impact									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) raod				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 70 from Rt 695, Catonsville, Balto., MD.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Virginia L. Dolan						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 6/24/81							
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.						ADDRESS 111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial				23b. DATE 6/27/81		23c. NAME OF CEMETERY OR CREMATORY Southlawn Memorial Park				23d. LOCATION CITY OR TOWN COUNTY STATE Prince George Co. Va.							
24. FUNERAL DIRECTOR Witzke Catonsville Funeral Home						ADDRESS 1630 Edmondson Ave. Catonsville, Md. 21034				DATE REC'D. BY REGISTRAR 26 1981							
25b. REGISTRAR'S SIGNATURE D. J. Kelly																	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 5 8 6

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Donna L. ALBRECHT			2a. DATE OF DEATH MONTH DAY YEAR June 5, 1981			2b. HOUR M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Nov. 9, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH PARKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2311 FOSTER AVE.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEC.	
12b. KIND OF BUSINESS OR INDUSTRY CARPET FASH.		13a. STATE MO.		13b. COUNTY BALTO.		13c. CITY OR TOWN PARKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST William H. ALBRECHT, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris M. CARMEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 70 7133	
17. INFORMANT ADDRESS FAMILY RECORDS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic malignant melanoma.</u> 1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 3)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/21/1980 to 6/3/1981, that (I) last saw the deceased alive on 6/3/1981, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Paul Chang, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/8/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL CHANG, M.D.		22e. ADDRESS 5601 LOCH RAVEN BOULEVARD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-9-1981		23c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE PARKVILLE BALTO. MD.	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL		ADDRESS 8800 HARFORD ROAD		25a. DATE REC'D. BY REGISTRAR JUN 16 1981		25b. REGISTRAR'S SIGNATURE T. J. McHenry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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18/10/18





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 5 8 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
JAMES WILLIAM ALSTON		June 25, 1981	
3. SEX		2b. HOUR	
Male		10:06 <sup>a</sup> M	
4. RACE		6. AGE (IN YEARS LAST BIRTHDAY)	
NEGRO		51 YRS.	
5. DATE OF BIRTH		IF UNDER 1 YEAR	
MONTH DAY YEAR 10 - 31 - 29		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Md.		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Rosevale		Franklin Square Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Inspector		Can Co.	
13a. STATE		13b. INSIDE CITY LIMITS?	
Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c. CITY OR TOWN		13d. STREET ADDRESS	
Baltimore		1053 N. Kenwood Ave.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST Henry Alston		FIRST MIDDLE LAST Minnie Eaton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
yes		217-24-2891	
17. INFORMANT		ADDRESS	
LEONA ALSTON		1053 N. Kenwood Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest 4148 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD - post fix myocardial infarction (c) DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER INQUIRY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 70, to May, 19 81, that (I) (we) lost saw the deceased alive on May, 19 81, and that in (my) (our) opinion death occurred on the day and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		22c. DATE SIGNED	
Eugenio E. Benitez MD		6/27/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
EUGENIO E BENITEZ MD		3455 W. KENS AVE 21229	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		6-29-81	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Arbutus Mem. PK.		Arbutus Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE RECD. BY REGISTRAR	
Randolph J. Collick		JUN 30 1981	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
2431 E. Oliver St.		R. J. Brady	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

ASCA - first six months of 1981

18 June 81

18 June 81

6/27/81

State of Illinois has 2152

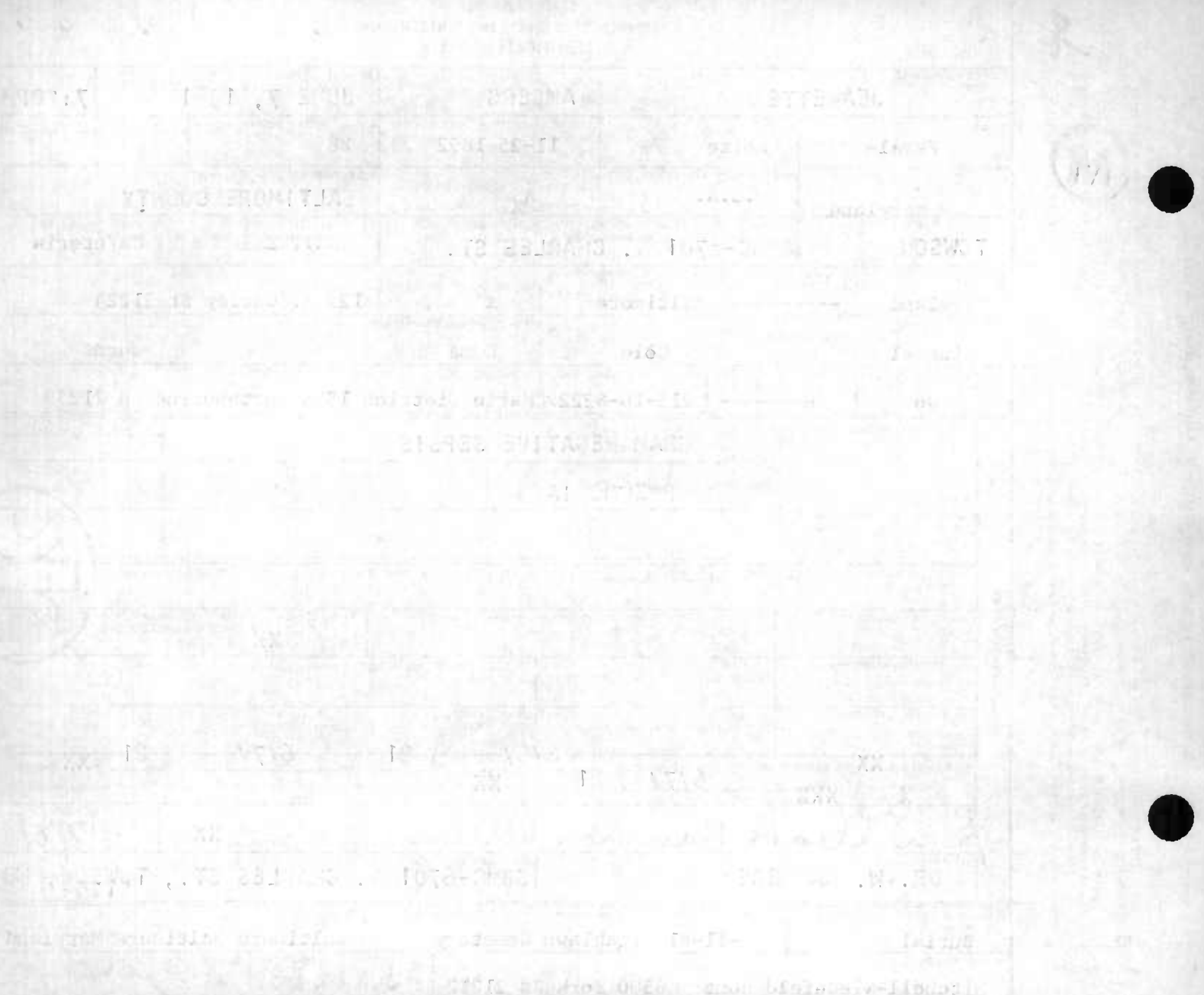
2152 = 2152

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>JEANETTE AMBERG</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 7, 1981</b>			2b. HOUR <b>7:20PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-25-1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS OR WORKING LIFE) <b>waitress</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Careteria</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. STREET ADDRESS <b>129 S. Curley St 21224</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Cole</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Burns</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>0-0-000000</b>		17. INFORMANT ADDRESS <b>Marie Dietrich 1534 Northbourne Rd 21239</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>GRAM NEGATIVE SEPSIS</b> IMMEDIATE CAUSE (a) <b>4860</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from <b>6/6/81</b> to <b>6/7/81</b> , that (we) lost <b>XX</b> above, (we) (did) <b>XX</b> view the body after death.			22b. SIGNATURE <b>William Kammerer MD</b>			22c. DATE SIGNED <b>6/7/81</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. W. KAMMERER</b>		
22e. ADDRESS <b>GBMC-6701 N. CHARLES ST., TOWSON, MD.</b>			22f. ADDRESS <b>GBMC-6701 N. CHARLES ST., TOWSON, MD.</b>			22g. ADDRESS <b>GBMC-6701 N. CHARLES ST., TOWSON, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-11-81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>			ADDRESS <b>6500 York Rd 21212</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 5 8 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William M. Amoss				2a. DATE OF DEATH MONTH DAY YEAR June 4, 1981		2b. HOUR 2:15a M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 20, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY LOCAL #48	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MO.				13b. COUNTY BALTO.		13c. CITY OR TOWN PARKVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST William P. Amoss				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR WATTERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-052548		17. INFORMANT ADDRESS FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) * PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary metastases from Rectal ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Rectal Carcinoma</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 9 months 2 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <u>May 13,</u> 19 <u>81</u> , to <u>June 4,</u> 19 <u>81</u> , that (X) (we) lost saw the deceased alive on <u>June 4,</u> 19 <u>81</u> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE * <u>James K. Smolev</u> MD				22c. DATE SIGNED June 4, 1981		22d. ADDRESS 550 N. Broadway, Suite 511, Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-6-1981		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM. BALTIMORE		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND	
24. FUNERAL DIRECTOR NAME EVANS FUNERAL CHAPEL 8800 HARFORD RD				25a. DATE REC'D. BY REGISTRAR JUN 9 1981		25b. REGISTRAR'S SIGNATURE <u>Robert M. Brady</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR					REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR			
ALEX A. ANDERSON					June 2, 1981					2:30p M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		CAUCASIAN		MONTH 11 DAY 21 YEAR 03		77 YRS.		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA		USA				Baltimore County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ROSSVILLE		FRANKLIN SQUARE HOSPITAL								PIPE MILL		STEEL	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
MARYLAND		BALTIMORE		ROSEDALE				8330 MILDRED AVE.					
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
OSCAR ANDERSON					JULIA JOHNSON								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
NO					213090536		ROMAYNE E. EINSCHUTZ 8338 ROFERD AVE.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest; Hepatic Encephalopathy 1175 DUE TO, OR AS A CONSEQUENCE OF (b) Cryptococcal Meningitis DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED													
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from May 10, 1981, to June 2, 1981, that (we) last saw the deceased alive on June 2, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.													
22b. SIGNATURE DEGREE										22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian R. Sims										22e. ADDRESS 9000 Franklin Square Drive - Balt. Md.			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL				6/5/81		GARDENS OF FAITH			BALTO. BALTO. MD.				
24. FUNERAL DIRECTOR John J. Cost 1211 Chesaco Ave.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
						JUN 5 1981							



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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 5 9 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANNINA DIVITANTONIO ANDREONE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 14, 1981</b>		2b. HOUR <b>2:45A.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 4, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>21234</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nursing Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Seamstress</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>21204</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pasquale DiVitantonio</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Domenica Serrani</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-09-8672</b>		17. INFORMANT ADDRESS <b>Yolanda A. Robb Baltimore, Md. 21204</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>May</u> 19 <u>81</u> , to <u>6-14</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6-12</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Marion C. Kowalewski M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-15-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marion C. Kowalewski, M.D.</b>		22e. ADDRESS <b>8604 Harford Road 668-7030</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 16, '81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>		ADDRESS <b>8521 Loch Raven Blvd</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>	25b. REGISTRAR'S SIGNATURE <b>L. J. Kelly</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 5 9 2

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>FRANK</b> <b>Richmond</b> <b>ARMSTRONG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-17-81</b> 2b. HOUR <b>10:08</b> M		
3. SEX <b>M</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MC DA YEAR <b>9-22-10</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NJ</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Baltimore County</b> MD		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>
13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Woodlawn</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>James W. Armstrong</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Abbie Richmond</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11</b>		17. INFORMANT <b>Mrs. Jean E. Armstrong</b> <b>2024 Russell Ave., Baltimore, MD 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE GASTROINTESTINAL BLEEDING</b> 5789 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>METASTATIC BLADDER CARCINOMA</b>					
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> <b>NO</b> <b>N/A</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6-16-81</b> P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-16-81</b> , to <b>6-17-81</b> , that (I) (we) last saw the deceased alive on <b>6-17-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>UNDYAC V REDDY</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL CITY OR TOWN <b>BALTIMORE</b> COUNTY <b>BALTIMORE</b> STATE <b>MD</b> DIRECTOR <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-17-81</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Woodlawn</b> COUNTY <b>Baltimore</b> STATE <b>MD</b>		24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Loring Byers</b>		25c. ADDRESS <b>8728 Liberty Rd., Randallstown, MD 21133</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GORDON W. ASHLEY, JR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 9 81</b>			2b. HOUR <b>P. M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 18 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Arbutus</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4308 Fordham Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Police</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. City</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Arbutus</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gordon W. Ashley, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Ash</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-05-2914</b>		17. INFORMANT ADDRESS <b>William Bolesta 5616 Chelwind Road 21227 Baltimore, Md.</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>1889</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>TRANSITIONAL CELL CARCINOMA OF BLADDER</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>N.T. Goodchild</b>				DEGREE <b>M.B.B.S.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11<sup>th</sup> June 1981</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. T. Goodchild, M.D.</b>				22e. ADDRESS <b>1900 E. Northern Parkway</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/12/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn Pk A.A. Co. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>				24b. ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

BP \_\_\_\_\_



JUN 13 1961



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

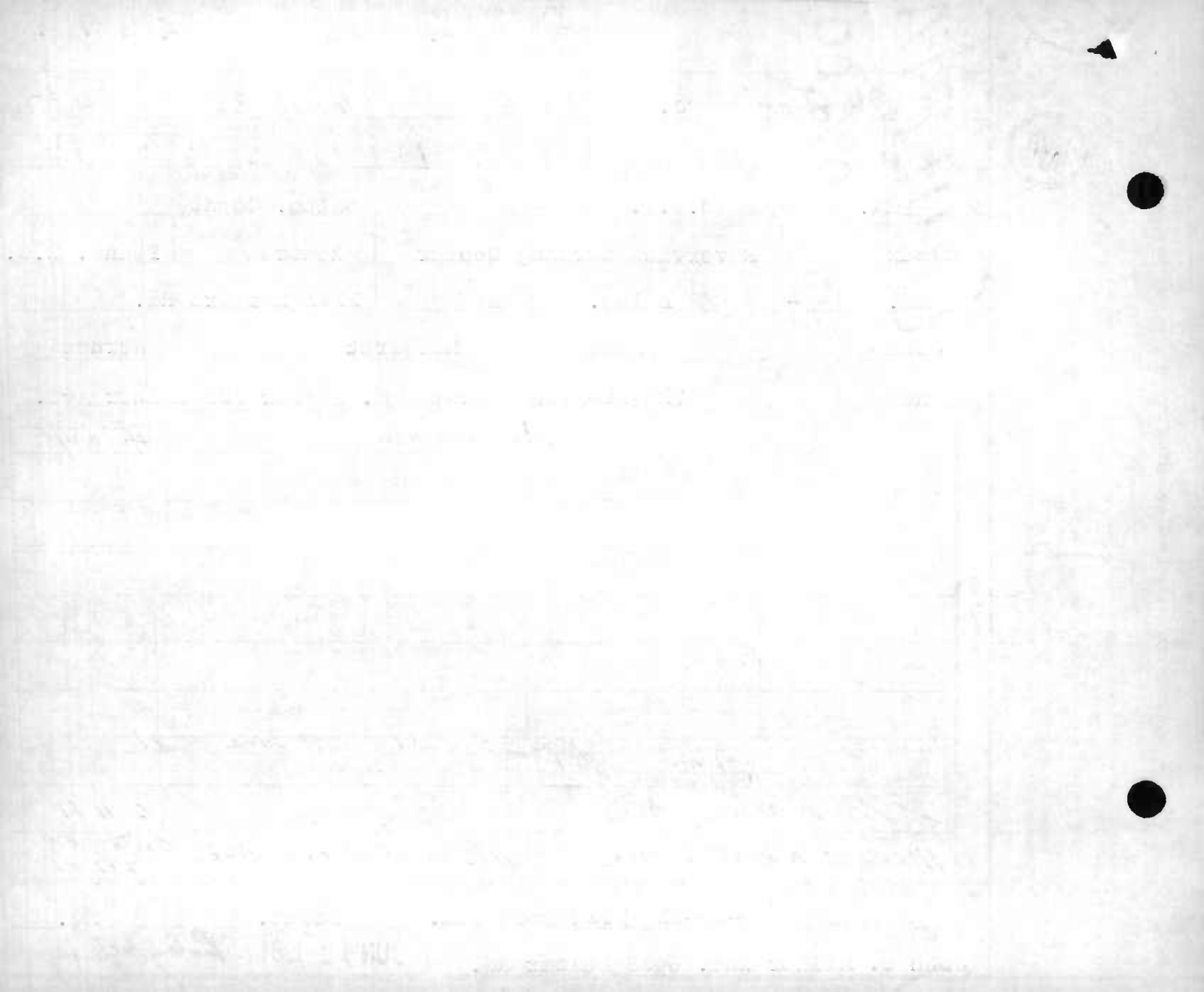
1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTIAN J. AUCK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-11-81</b>			2b. HOUR <b>4 30 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 7 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Essex</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Riverview Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Penna. R.R.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2141 Harford Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Auck</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Werner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>716-12-3725</b>		17. INFORMANT ADDRESS <b>Dorothy M. Fisher 125 Elinor Ave.</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> 7 4860 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 23 1981</b> to <b>11 June 1981</b> , that (I) (we) last saw the deceased alive on <b>9 June 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) use the body after death.									
22b. SIGNATURE <b>M. Rainess, MD</b> DEGREE						22c. DATE SIGNED <b>6-11-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRIS RAINESS, MD</b>						22e. ADDRESS <b>1105 OLD EASTERN AVE. Balto. Md. 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-13-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>John C. Miller Inc. 6415 Belair Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy M. Fisher</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be notified).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	5	9	5		
FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIRGINIA A. BAADER</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>06 20 81</b>							2b. HOUR <b>10<sup>37</sup> AM</b>	
3. SEX <b>FEMALE</b>			4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 11 24</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>		IF UNDER 24 HRS. HOURS MIN. <b>00 00</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>									
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4 YORK MILLS COURT</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESLADY</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>							
13a. STATE <b>MARYLAND</b>										13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>4 YORK MILLS COURT, 21228</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMMITT BABER</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCY J. HUT</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>218-18-3588</b>			17. INFORMANT ADDRESS <b>NORMAN H. BAADER 4 YORK MILLS COURT, 21228</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2030</b> IMMEDIATE CAUSE (a) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
21g. I certify that (I) (this hospital) attended the deceased from <b>7/9</b> 19 <b>79</b> , to <b>6/18/80</b> 19 <b>81</b> , that (I) (we) lost <b>1</b> saw the deceased alive on <b>6/18/80</b> 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death, so state.)																		
22a. SIGNATURE <b>Diana Griffiths</b>										DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/22/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DIANA GRIFFITHS, M.D.</b>										22e. ADDRESS <b>ST. AGNES HOSPITAL, ONCOLOGY DEPT.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>06-23-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWRIDGE MEM. PK.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELKRIDGE HOWARD MARYLAND</b>								
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>										ADDRESS <b>4107 WILKENS AVE.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

10/10/70

TO: [illegible] FROM: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

DATE: [illegible]

BY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 5 9 6	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST HOPE		MIDDLE V.		LAST BAGLEY		2a. DATE OF DEATH MONTH DAY YEAR JUNE 17, 1981		2b. HOUR 7:55 M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1 26 04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ST. JOSEPH HOSPITAL (IF NOT IN BALTIMORE, GIVE STREET AND CITY)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 506 E. 27th St.			
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Grubb				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lolly Jackson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Kenneth Davis 506 E. 27th St.							
18. CAUSE OF DEATH (Enter only one cause death due to (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ANOXIC BRAIN DAMAGE</b> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (the hospital) attended the deceased from <u>JUNE 17</u> , 19 <u>81</u> , to <u>JUNE 17</u> , 19 <u>81</u> , that (he) (she) last saw the deceased alive on <u>JUNE 17</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Anthony G. Lewandowski</i> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>06-17-81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTHONY A LEWANDOWSKI MD						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/81		23c. NAME OF CEMETERY OR CREMATORY King Memorial Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR JUN 19 1981		25b. REGISTRAR'S SIGNATURE <i>Anthony A. Lewandowski</i>			

36

NOV 19 1944

RECEIVED

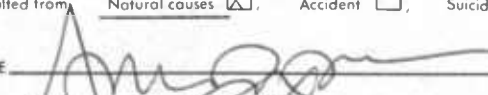

NOV 19 1944

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NOV 19 1944

RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF YOU FILE, RETURN TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14597	
1. DECEASED NAME (TYPE OR PRINT) <b>Chauncey Eugene Bair Sr.</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 23 1981</b>		2b. HOUR <b>9:30</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3/17/1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3231 Offutt Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Turn Foreman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mfrg.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>----</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3104 Clearview Ave. 21234</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Enoch Matson Bair</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ella Nelson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>276.10.8447</b>		17. INFORMANT <b>Edward B. Bair</b> ADDRESS <b>3928 Grimm Road Jarrettsville, Md. 21084</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b>		DATE SIGNED <b>6/24/81</b>		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>6/25/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Walter Brooks Bradley Inc., Dundalk Md 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1981</b>		25b. SIGNATURE 			



*Handwritten signature or mark.*

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 5 9 8

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Edythe R. Baker		MONTH DAY YEAR June 10 1981	
3. SEX Female		2b. HOUR 11:17 <sup>M</sup>	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH 11 <sup>TH</sup> 29 <sup>DAY</sup> 1893 <sup>YEAR</sup>		87 <sup>YRS.</sup>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) California		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Towson		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian	
12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13c. CITY OR TOWN Aberdeen		13d. STREET ADDRESS 34 W. Bel Air Ave. 21001	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Wells	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 110		16b. SOCIAL SECURITY NO. 212-28-7501	
17. INFORMANT ADDRESS 642 Burkley Ave. Aberdeen, MD 21001			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from June 9, 1981, to June 10, 1981, that (X) (we) last saw the deceased alive on June 10, 1981, and that (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) did not view the body after death.			
22b. SIGNATURE Maurice B. Furlong, M.D.		22c. DATE SIGNED June 10, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 67620 York Rd. Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 12, 1981	
23c. NAME OF CEMETERY OR CREMATORY Baker's CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ABERDEEN HARTFORD MD.	
24. FUNERAL DIRECTOR NAME TARRINK FUNERAL HOME, P.A.		25. REGISTRAR'S SIGNATURE JUN 16 1981	



2025 RELEASE UNDER E.O. 14176

*[Faint, mostly illegible text and markings, possibly a signature or stamp, with a large 'X' visible on the left side.]*



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Lester R. Baker								6/12/81								4:45AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
Male		White		5 30 18		63		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Freeland		2309 Bull Saw Mill Road		Laborer		Recreation											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Balto.		Freeland		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2309 Bull Saw Mill Road									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Jarrett		Elizabeth															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WWII		218-05-9921		Mary T. Baker		2309 Bull Saw Mill Rd.								Freeland, Md. 21053	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Acute myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4100				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)													
				DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION													
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 6/2 1980, to 6/12 1981, that (I) (we) last saw the deceased alive on 3/23 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
D. V. Faustino, M.D.		M.D.		6/12/81													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		4. ADDRESS															
		4111 Lower Beckleysville Road															
		Hampstead, Md. 21074															
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		6-15-1981		Bethlehem Cem.		Glen Rock, York, Penna.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
J. Hartenstein		JUN 16 1981		New Freedom, Pa.													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>AKA: LOUIS BERNARD BAKER</b> <b>LOUIS B BAKER</b>		MONTH DAY YEAR <b>6-14-81</b>		HOURS MIN. <b>11:15 PM</b>	
3. SEX <b>male</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>8-23-1877</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>		
10. CITY OF DEATH <b>FOWSON</b> <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Parkville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>2903 Linganore Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dorsey L. Baker</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lilly M. Norwood</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW I</b>		16b. SOCIAL SECURITY NO. <b>215-10-8112</b>		17. INFORMANT ADDRESS <b>Margaret E. Baker, 2903 Linganore Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4280</b> IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> <b>CHD</b> DUE TO, OR AS A CONSEQUENCE OF <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) _____ (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-8-81</b> to <b>6-14-81</b> , that (I) (we) lost saw the deceased alive on <b>6-14-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>G D Harvey</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-14-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY HARVEY</b>		22e. ADDRESS <b>ST JOSEPH'S HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 17, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Md.</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>		23f. REGISTRAR'S SIGNATURE <b>Robert C. Altenburg</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b> <b>6009 Harford Rd., Balto., Md. 21214</b>					

CHILDREN OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		2. DEPARTMENT OF HEALTH AND MENTAL HYGIENE		3. REG. NO.	
Per. F.H. 6/9/81 GB		Items #5&6 Film G556		8 1 1 4 6 0 1	
6/18/81 rc		CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		
FIRST MIDDLE LAST Eleanor Balcer			MONTH DAY YEAR 6 5 81		
3 SEX			2b. HOUR 8:15A M		
Female					
4 RACE			6 AGE (IN YEARS LAST BIRTHDAY)		
Cauc.			52 YRS		
5. DATE OF BIRTH			IF UNDER 1 YEAR		
MONTH DAY YEAR 2 22 1929			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9 BALTIMORE CITY OR COUNTY OF DEATH		
Md.			Baltimore County MD		
7b. CITIZEN OF WHAT COUNTRY?			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
U.S.A.					
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			12b. KIND OF BUSINESS OR INDUSTRY		
10. CITY OR TOWN OF DEATH					
Towson					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					
GBMC 6701 N. Charles St. 21204					
13a. STATE			13b. COUNTY		
Md.			Baltimore		
13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST Carroll Balcer			FIRST MIDDLE LAST Josephine Olszewska		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
No			213-26-2993		
17. INFORMANT			ADDRESS		
Tillie Tallarico			3559 Elmora Ave		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardio Respiratory Arrest					
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic CA of the Breast					3 Years
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/4, 19 81, to 6/5, 19 81, that (I) (we) lost the deceased alive on 6/5, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Ahmed S. Shafik, M.D.				6/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Ahmed S. Shafik, M.D.				6701 N. Charles St. 21204	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/8/81		Gardens of Faith	
				23d. LOCATION CITY OR TOWN COUNTY STATE	
				Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR	
B. Dabrowski & Son 2818 E. Baltimore St.				JUN 9 1981	
				25b. REGISTRAR'S SIGNATURE	

E. Ishikawa & Son 2418 E. Baltimore St. Baltimore Md.  
6/8/81  
Baltimore

215-08-1993 Little Baltimore Md. 1900

Serial 1900 Little Baltimore Md. 1900

Serial 1900 Little Baltimore Md. 1900

Serial 1900 Little Baltimore Md. 1900

Serial 1900 Little Baltimore Md. 1900

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GERTRUDE NAOMI BARRY</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6 2 81</b>		2b. HOUR <b>9:35 AM</b>
3. SEX <b>F</b>	4. RACE <b>CAUC</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 24 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.
10. CITY OR TOWN OF DEATH <b>ARBUTUS</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>951 CIRCLE DRIVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>STRAW HAT</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>ARBUTUS</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-60-0620</b>		17. INFORMANT ADDRESS <b>COLUMBIA, MD.</b>
		17. INFORMANT NAME <b>LERLYNE N. BURROWS</b>		
		17. INFORMANT ADDRESS <b>6255 AUDUBON DRIVE</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA LUNG</b> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **11-2**, 19 **79**, to **6-2**, 19 **81**, that (I) ~~was~~ lost saw the deceased alive on **5-27**, 19 **81**, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~was~~ (did) ~~not~~ view the body after death.

22a. SIGNATURE <b>Laurence R. Gallagher, M.D.</b>	DEGREE <b>M.D.</b>	22c. DATE SIGNED <b>6-2-81</b>
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LAURENCE R. GALLAGHER</b>	22c. ADDRESS <b>ST AGNES MEDICAL CENTER WILKENS + PINE HEIGHTS, BALTO, MD 21229</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>06-05-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>
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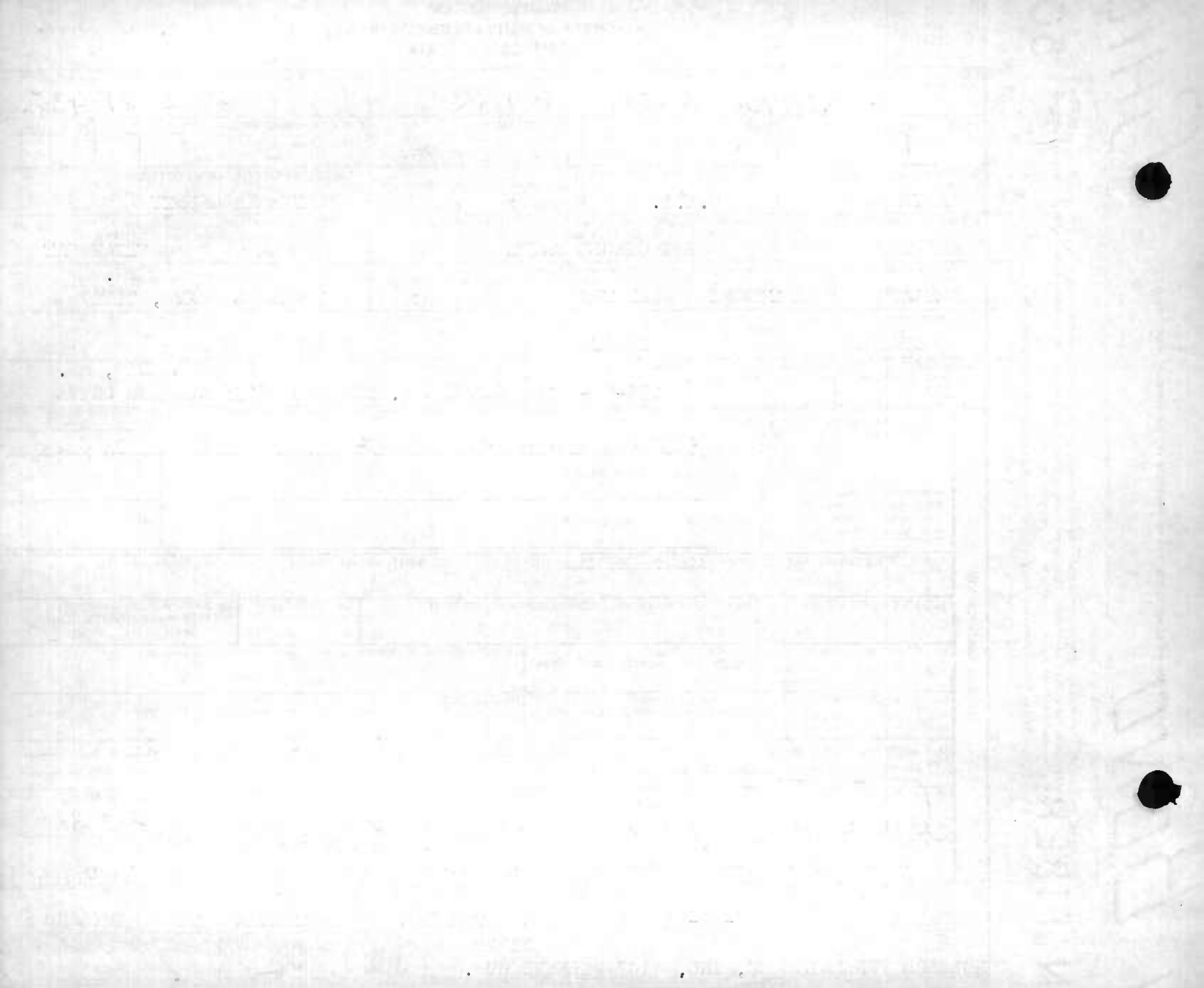
24. FUNERAL DIRECTOR NAME <b>HUBBARD FUNERAL HOME, INC.</b>	ADDRESS <b>4107 WILKENS AVE.</b>	25a. DATE REC'D. BY REGISTRAR <b>JUN 3 1981</b>	25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8114603			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ida May Bartels				2b. HOUR 330 M			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR DEC 17 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Bailto. Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Kingsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12311 Javicho Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homekeeping	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md 13b. COUNTY Bailto. 13c. CITY OR TOWN Kingsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 12311 Javicho Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Francis W. Ashen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Carback			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 212-50-6616		17. INFORMANT ADDRESS William L. Bartels 12311 Javicho Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Feb 19 71, to June 19 81, that (I) (we) lost saw the deceased alive on June 2 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William L. Tyson M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-6-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. A. Tyson				22e. ADDRESS Kingsville Md 21087			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/8/81		23c. NAME OF CEMETERY OR CREMATORY Westview Cmn.		23d. LOCATION CITY OR TOWN COUNTY STATE Westview Bailto. Md.	
24. FUNERAL DIRECTOR NAME E.F. Lassus Jr F.H.				25a. DATE REC'D. BY REGISTRAR JUN 10 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



*[Faint, illegible handwriting on lined paper, possibly a ledger or notebook page. The text is mirrored across the page, suggesting bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 0 4

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CIARENCE E. BARTH, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 4, 1981</b>			2b. HOUR M	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 4 - 21</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TRUCK DRIVER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>OIL Co.</b>							
13a. STATE <b>MD.</b>							
13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTO.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>716 MORANE WAY</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CLARENCE E. BARTH, SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANASTASIA HOUSTON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-03,8328</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret C. Barth, - 716 Morane Way</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>CARDIO-PULMONARY arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF: (b): <b>acute coronary</b> DUE TO, OR AS A CONSEQUENCE OF: (c): <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b></b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b></b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> 19 <b>81</b> , to <b>6/3</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/3</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>ELMO M. GAYOSO</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-4-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELMO M. GAYOSO, M.D.</b>				22e. ADDRESS <b>5411 Old FREDERICK Rd #8 BALTO MD 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-8-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR <b>Barth, Millie - 7527 Harford Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 8 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. Kennedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1914 4/10 H-1

WABCE

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12-11-11

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Handwritten notes and calculations, including the word "Transit" and various numbers and symbols.



Handwritten signature or initials at the bottom left.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession of this certificate is required for the burial of the deceased. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Anthony Raymond Baum</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>6 19 1981</b>		2b. HOUR A M <b>6:00 A</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9/25/1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>69</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto., Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6 Kirk Hill Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aerospace &amp; Fed. Gov't.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Perry Hall</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>10619 Philadelphia Rd. 21128</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Valentino Baum</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Wagner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>216.05.4794</b>		17. INFORMANT ADDRESS <b>Charles V. Baum 9303 Gardenia Rd. Baltimore, Md. 21236</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4149</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe CHF, Ischemic Cardiomypopathy.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cor. art. disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>2-3 yrs</b> <b>6-8 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>									
19a. DATE OF OPERATION <b>1</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (a) (this hospital) attended the deceased from <b>5/29/81</b> to <b>6/17/81</b> that (b) (we) lost the deceased alive on <b>6/17/81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gauhar</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/19/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. GAUHAR</b>						22e. ADDRESS <b>5400 old Ct. Rd. Pundallstown MD 21133</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Walter Brooks Bradley Inc. Balto., Md 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>	

Carroll's Carriage  
Selling Cars, Trucks, Buses -  
Cor. 1st & 2nd St.  
6-8-79

17 6/17/81

W. B. BAKER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Maria BAXLEY			2a. DATE OF DEATH MONTH DAY YEAR June 1, 1981		2b. HOUR 4:00 <sup>a</sup>
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 11/30/19	6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT
13a. STATE MD	13b. COUNTY BALTO	13c. CITY OR TOWN EASTPONT	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 430 SCARSDALE	
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY GIORDANO			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST THERESA STELLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 249884	17. INFORMANT ADDRESS CLIFTON BAXLEY ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small cell Cancer of lung with brain metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Pleural Effusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from May 22, 1981, to June 1, 1981, that (we) lost (saw the deceased alive on June 1, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) view the body after death.					
22b. SIGNATURE Michael Koger MD				22c. DATE SIGNED 6/1/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Koger, M.D.				22e. ADDRESS 9000 Franklin Square Drive 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVED		23b. DATE 6/3/81	23c. NAME OF CEMETERY OR CREMATORY ST. PETERS		23d. LOCATION CITY OR TOWN COUNTY STATE MERRIAM PA
24. FUNERAL DIRECTOR NAME J.B. CONNELLY		ADDRESS 300 MALE		25a. DATE REC'D. BY REGISTRAR JUN 9 1981	





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10/20/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
8 1 1 4 6 0 7											
1. FOR STATE REGISTRAR											
CERTIFICATE OF DEATH											
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RALPH E. BEACH.					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 6 21 81 45 <sup>22</sup> <sub>M</sub>						
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 6 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH RANDALSTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTO COUNTY GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GOLF PRO.		12b. KIND OF BUSINESS OR INDUSTRY SELF			
13a. STATE Md.					13b. COUNTY BALTO.		13c. CITY OR TOWN PIKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES S. BEACH					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE ENNIS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 213-01-7598-A		17. INFORMANT MRS. LUCY A. BEACH			ADDRESS (SAME)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia. 2500 DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal Failure 6 months DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus ?											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/22, 19 81, to 6/21, 19 81, that (I) (we) lost saw the deceased alive on 6/21, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Roberto E. Turnbull M.D.					DEGREE		22c. DATE SIGNED 6/21/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roberto E. Turnbull M.D.					22e. ADDRESS Balto County Genl Hosp.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/24/81		23c. NAME OF CEMETERY OR CREMATORY Dw. D RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE Balto. Md.				
24. FUNERAL DIRECTOR NAME NEWELL F. H. PIKESVILLE, Md.					25a. DATE REC'D. BY REGISTRAR JUN 23 1981		25b. REGISTRAR'S SIGNATURE Jeffrey McQuinn				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Dewey I.		MIDDLE L.		LAST Belt		2a. DATE OF DEATH		MONTH 6		DAY 22		YEAR 81		2b. HOUR 10 <sup>15</sup> A.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH		MONTH 2		DAY 27		YEAR 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82		IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.											
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JW Hall Nursing Home															
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Esskay Co.															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 19 Harrison Place									
14. FATHER'S NAME FIRST FRANK		MIDDLE		LAST Belt		15. MOTHER'S MAIDEN NAME FIRST MARY		MIDDLE Snyder		LAST Easthampton, Mass							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-2405		17. INFORMANT Mrs. Mary C. Domzalski 10 Melenda Lane													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 1850 } DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of Prostate (c) Cancer of Brain DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Cancer of Brain																	
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 19 81, to Jan 20, 19 81, that (I) (we) lost saw the deceased alive on Jan 20, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Irving R. Beck MD		DEGREE		22c. DATE SIGNED 6-22-81													
22d. PHYSICIAN'S NAME (TYPE OR PRINT) IRVING R. BECK MD		22e. ADDRESS 901 FUSELAGE Av Balto. Md 21220															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 25, 1981		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN Baltimore,		COUNTY Md. STATE									
24. FUNERAL DIRECTOR Leonard J. Ruck Inc, Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 24 1981															
		25b. REGISTRAR'S SIGNATURE Rickey Kebrudy															

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*[Faint handwritten notes at the bottom of the page]*

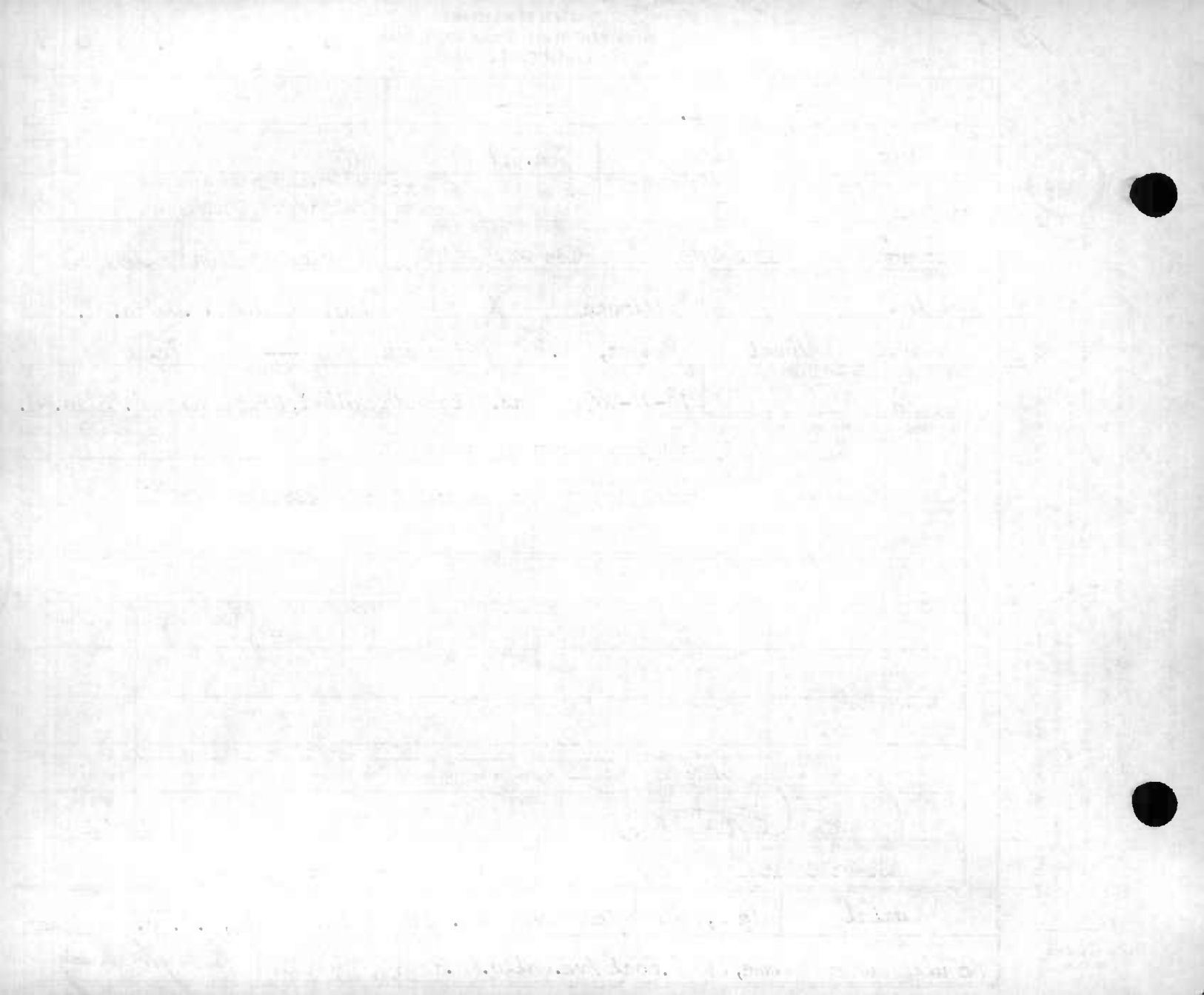
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 0 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edward L. Berger			2a. DATE OF DEATH MONTH DAY YEAR 6 29 81		2b. HOUR 12:13P <sub>M</sub>
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Jan. 5, 1914	6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	9. CITIZEN OF WHAT COUNTRY? USA	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
12. CITY OR TOWN OF DEATH Towson	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. Charles St. 21204		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Service Station	15. KIND OF BUSINESS OR INDUSTRY Attendant	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Maryland			16b. COUNTY Baltimore	16c. CITY OR TOWN Baltimore	16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
17. STREET ADDRESS 1404 William St. Balto. Md.			18. MOTHER'S MAIDEN NAME Elizabeth Petty		
19. FATHER'S NAME John Albert Berger, Sr.			20. MOTHER'S MAIDEN NAME Elizabeth Petty		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			22. SOCIAL SECURITY NO. 218-01-9891		
23. INFORMANT Mrs. Elizabeth Waibel, 1052 Upnor Rd. Balto. Md.			24. ADDRESS		
25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Carcinoma Oral Cavity (Squamous Cell) DUE TO, OR AS A CONSEQUENCE OF (c) 1459 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
26a. DATE OF OPERATION		26b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE	
29. I certify that (I) (this hospital) attended the deceased from 6/24, 19 81, to 6/29, 19 81, that (I) (we) lost saw the deceased alive on 6/29, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, and (if) (did) not with the body after death.					
30. SIGNATURE Robert Capitelli				31. DATE SIGNED 6/29/81	
32. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Capitelli, M.D.				33. ADDRESS 6701 N. Charles St. 21204	
34. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		35. DATE July 2, 1981		36. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park	
37. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A. A. Maryland		38. FUNERAL DIRECTOR NAME ADDRESS McGully Funeral Home, 130 E. Fort Ave. Balto. Md.			
39. DATE REC'D. BY REGISTRAR JUN 30 1981		40. REGISTRAR'S SIGNATURE [Signature]			



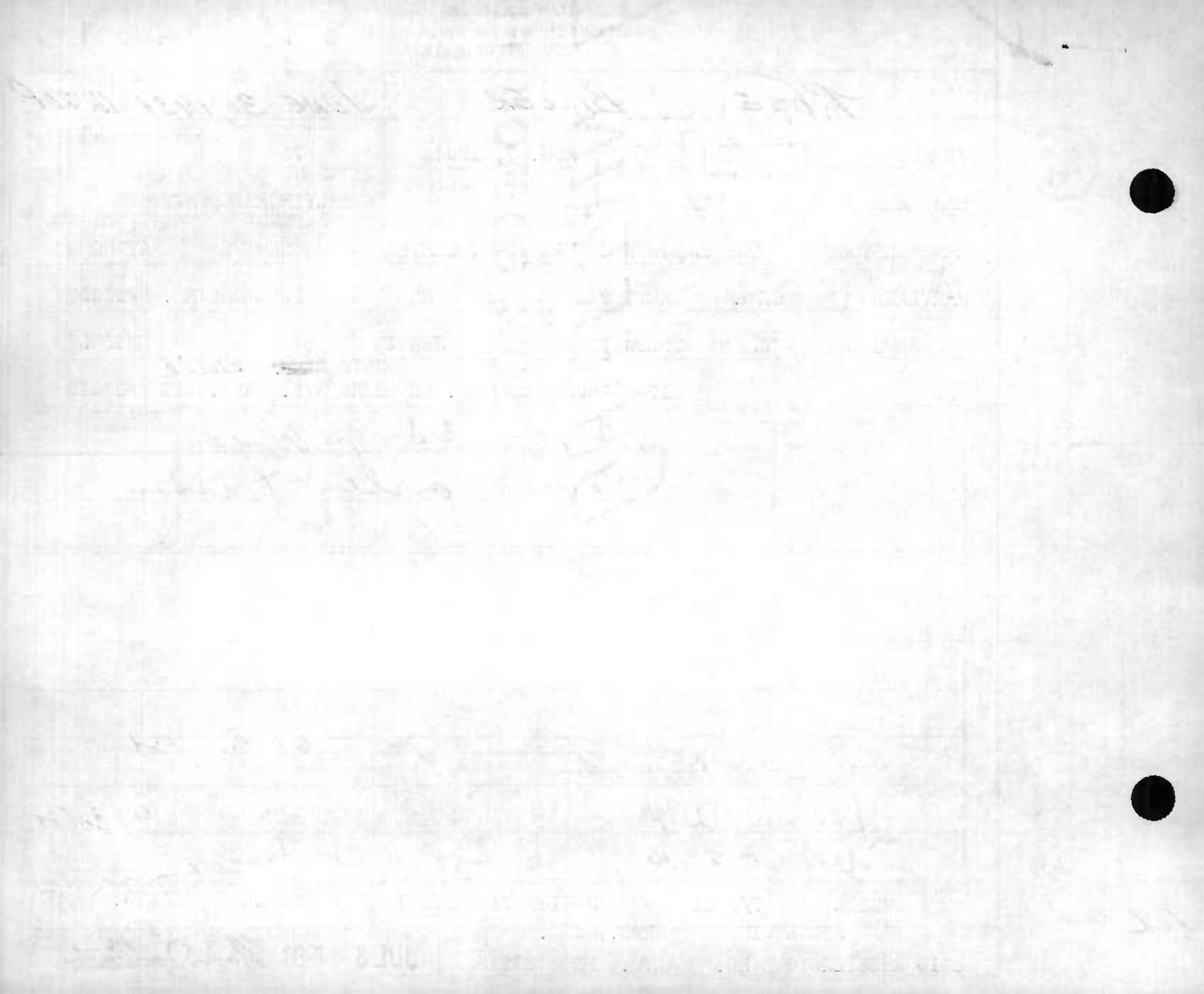


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 1 0	
FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ROSE BILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 30, 1981</b>		2b. HOUR MIN. <b>12:20 P.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>AUG. 7, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RANDALLSTOWN CONVALESCENT CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>SAMUEL T. BERLOWITZ</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JENNIE MEISEL</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-32-8006</b>		17. INFORMANT <b>MORRIS BILLER</b> <b>2500 W. BELVEDERE AVE., APT. 618 #21215</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Altered mental function</b> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/15</b> , 19 <b>78</b> , to <b>6/30</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/15</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Samuel W. Wolfson</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/30/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WOLFSON</b>		22e. ADDRESS <b>3502 W. ROGUE</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>	
23d. LOCATION CITY STATE <b>ROSEDALE BALTO. MD</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
25a. DATE REC'D. BY REGISTRAR <b>JUL 8 1981</b>		25b. REGISTRAR'S SIGNATURE <b>James J. [Signature]</b>			



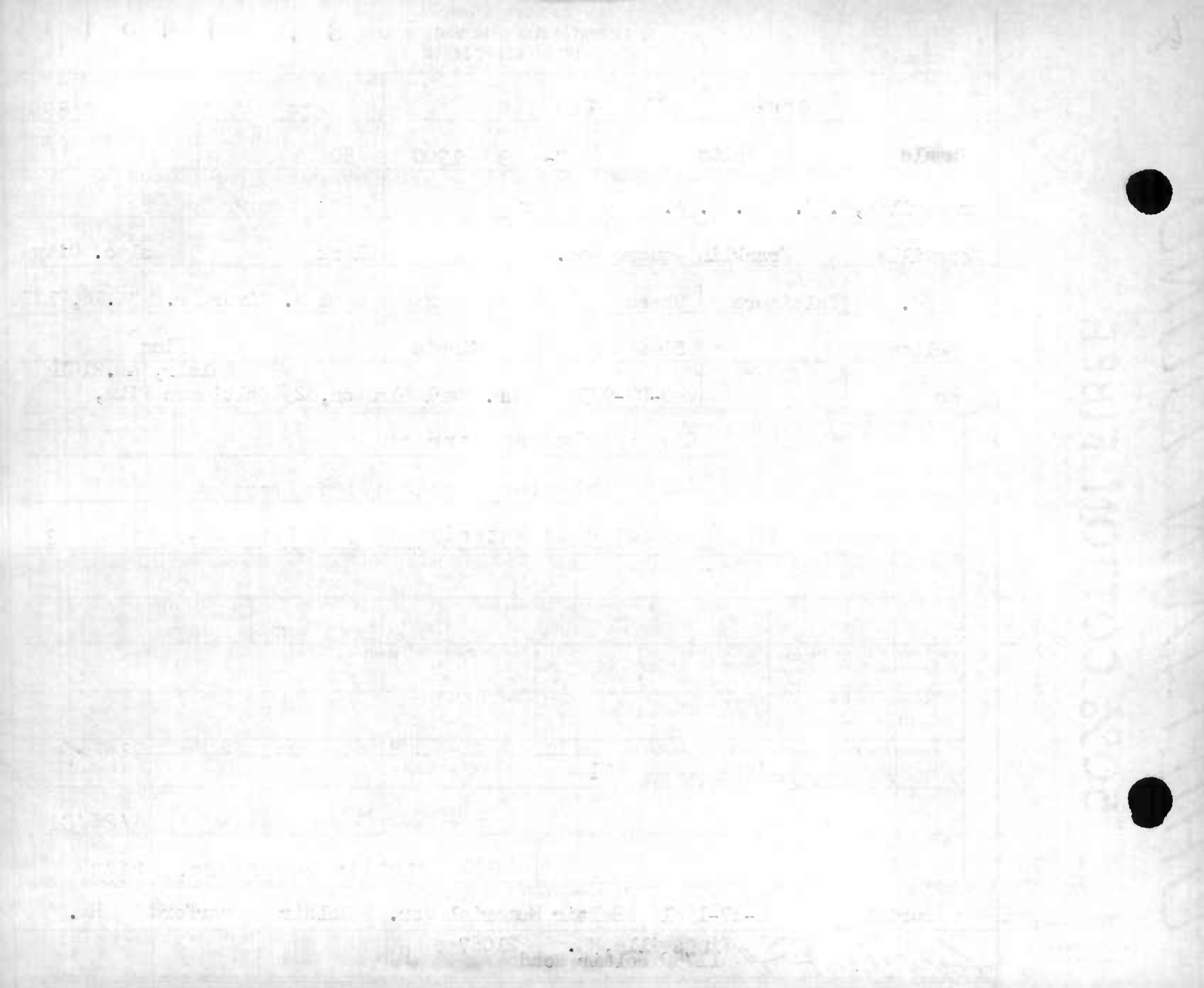
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 1 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Carrie Belle BLANTON				2a. DATE OF DEATH MONTH DAY YEAR June 24, 1981		2b. HOUR 8:53 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7- 3 1900		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greenville, N. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hos.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Balto. City	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Chase		13e. STREET ADDRESS 6801 N. River Dr. Rt. 16, 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Belton Sims				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie King			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 240-07-9839		17. INFORMANT ADDRESS Belair, Md. 21014 Mr. Earl Blanton, 825 Baltimore Pike,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } (b) Acute anterior myocardial infarction gave rise to immediate } cause (a), stating the } underlying cause last. } (c) Status post anterior myocardial infarction X 2 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from June 4, 1981, to June 24, 1981 that (we) last saw the deceased alive on June 24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) will (shall) view the body after death.							
22b. SIGNATURE DEGR.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. R. FERNANDEZ				22e. ADDRESS 9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-27-1981		23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Belair Harford Md.	
24. FUNERAL DIRECTOR NAME Lassahn F. J. Kingsville, Md. 21087 11750 Belair Road				25a. DATE RECD. BY REGISTRAR JUN 29 1981		25b. REGISTRAR'S SIGNATURE 	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8114612

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <b>ALFRED BODDICE</b>			MONTH DAY YEAR <b>6 16 81</b>			3:50A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<b>MALE</b>	<b>WHITE</b>	MONTH DAY YEAR <b>2 19 18</b>	<b>63</b> YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
<b>Pennsylvania</b>			<b>U.S.A.</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FORMER OR WORKING LIFE)		
<b>TOWSON</b>			<b>GBMC-6701 N. CHARLES ST.</b>			<b>Pipe Mill Worker</b>		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
<b>Maryland</b>			<b>Baltimore</b>			<b>Mid. River</b>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13d. STREET ADDRESS		
FIRST MIDDLE LAST <b>William Boddice</b>			FIRST MIDDLE LAST <b>Florence Mack</b>			<b>111 Conestoga Road</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
<b>No</b>			<b>213-09-3367</b>			<b>Martha S. Boddice-Middle River, MD. 21220</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENO CA OF LUNG WITH BONE METASTASIS</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>5-26</b> , 19 <b>81</b> , to <b>6-16</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <b>Richard Jacobson MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-16-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. JACOBSON, M.D.</b>			22e. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/19/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> 7922 Wise Avenue Dundalk, MD. 21222			25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1981</b>			25b. REGISTRAR'S SIGNATURE <i>Richard Jacobson</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Vital Records.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MALE

WHITE

2 19 18

63

BALTIMORE COUNTY

TOWSON

GBMC-6701 N. CHARLES ST.

RESPIRATORY ARREST

ADENO CA OF LUNG WITH BONE METASTASIS

X

6-16

81 5-26

81

6-16

81

N. JACOBSON, M.D.

GBMC-6801 N. CHARLES ST.

X

6-16-81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
DECEASED NAME (TYPE OR PRINT) <b>WILLIAM B BOONE Sr.</b>					DATE OF DEATH MONTH DAY YEAR <b>06/29/81</b> 2b. HOUR <b>6:30PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 8 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH <b>COUNTY Baltimore MD.</b>			
9. CITY OR TOWN OF DEATH <b>TOWSON</b>		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPHS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>St. of Md.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Fallston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3224 Canterbury Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John H Boone</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Smiley</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW1</b>					16b. SOCIAL SECURITY NO. <b>220 36 8284</b>		17. INFORMANT ADDRESS <b>William B. Boone Jr Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest. CARDIAC ARREST</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
21a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>06/26/81</b> , 19 <b>81</b> , to <b>06/29</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>06/29</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (we) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death.									
22b. SIGNATURE <b>Y. A. Tomhe, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>YASEEN A TOMHE, M.D.</b>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/3/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>					25a. DATE REC'D BY REGISTRAR <b>JUL 6 1981</b>		25b. REGISTRAR'S SIGNATURE		



2:30M

CLASSICAL

WILLIAM J. MOORE

MALE

COUNTY

ST JOSEPH HOSPITAL

TOBACCO

CARDIAC ARREST

CLASSICAL

DEARS

YASSEN A. TORRE, M.D.

DEPT. 1

1000 11th Avenue, New York 100

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LUCY E. BOWEN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 1, 1981</b>		2b. HOUR <b>3:00A</b>						
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 18, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>21234</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley Convalescent Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Button Hole Maker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21204</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1000 E. Joppa Road Apt#508</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Warfield S. Pierce</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie E. Tracey</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-03-2129</b>		17. INFORMANT ADDRESS <b>Lucille R. Quinan 902 Rapax Ct. 21204</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><b>Arteriosclerotic Cardiovascular Disease</b></u> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u><b>10/31</b></u> , 19 <u><b>74</b></u> , to <u><b>6/1</b></u> , 19 <u><b>81</b></u> , that (I) (we) lost saw the deceased alive on <u><b>5/27/81</b></u> , 19 <u><b>81</b></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u><b>Kevin Quinn</b></u>						DEGREE <b>M.D.</b>			22c. DATE SIGNED <b>6/1/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Kevin Quinn, M.D.</b>						22e. ADDRESS <b>1205 York Road 823-2080</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 3, '81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>		
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 2 1981</b>			25b. REGISTRAR'S SIGNATURE <u><b>[Signature]</b></u>		
ADDRESS <b>8521 Loch Raven Blvd.</b>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

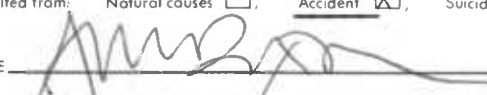

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARENCE E. BRAYE III			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 5 19 81			2b. HOUR M 11pM		
3. SEX male	4. RACE negro	5. DATE OF BIRTH MONTH DAY YEAR 7 5 63	6. AGE (IN YEARS) (LAST BIRTHDAY) 17 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 5 19 81		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Patapsco State Park (dam)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY Balto	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6603 Laural Drive		
14. FATHER'S NAME FIRST MIDDLE LAST Clarence E. Bray Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Betty Collins				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Clarence E. Bray Jr. 6603 Laural		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 9108 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 3:10P.M. 6-5- 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject jumped into dam and drowned.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) dam		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Patapsco State Park Balto. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 6-6-81		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/81		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Norfolk VA		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 9 1981		25b. REGISTRAR'S SIGNATURE 



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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

10/1/88

10/1/88

DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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DATE 10/1/88 BY SP-5 [illegible]

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DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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10/1/88

DATE 10/1/88 BY SP-5 [illegible]

REASON: [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		3 1 1 4 6 1 6		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b. DATE OF DEATH			2b. HOUR
NEVA L. BRISCOE						MONTH	DAY	YEAR	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR
FEMALE			WHITE		MONTH DAY YEAR		84		MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Michigan			USA				BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
TOWSON			GBMC-6701 N. CHARLES ST.			Saleslady		Miller Bros/	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS
Md.			Balto.		Cockeysville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19 Cockeysville Road
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
James S. Stackus			Martha McShea						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
no			328 03 1700			family records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST									15 MIN.
1830 DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF THE OVARY									9 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR						
			P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					STREET CITY OR TOWN COUNTY STATE				
					6-13 81 6-22 81				
22a. I certify that (I) (this hospital) attended the deceased from 6-22 81 to 6-22 81, that (I) (we) lost saw the deceased alive on 6-22 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
MICHAEL B. GRIECO, M.D.								6/22/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
MICHAEL B. GRIECO, M.D.			GBMC-6701 N. CHARLES ST.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
cremation			6/22/1981		Westview		CITY OR TOWN COUNTY STATE		
							Balto. County, Md.		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
ERANIS Funeral Chapel			JUN 26 1981			Lillian McCreedy			

BALTIMORE COUNTY

100-2701 H CHARLES ST.

100-2701

12 MIN  
2 YEARS

CAPITULATION OF THE CRAY  
"CAPITULATION OF THE CRAY"

6-22 6-22 6-22 6-22 6-22

100-2701

100-2701 H CHARLES ST.

MICHAEL ST. BALTIMORE, MD.



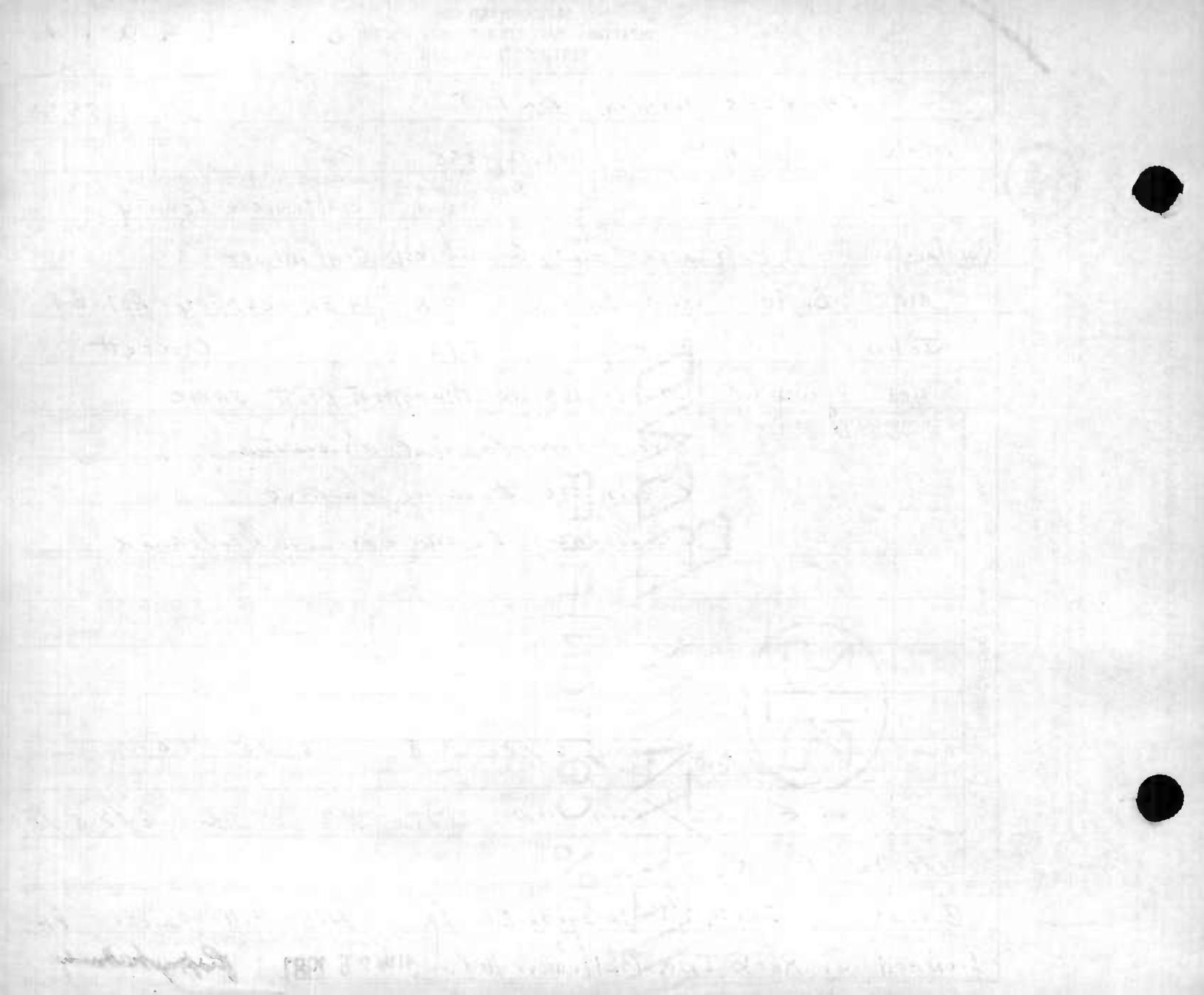
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8114617	
FOR 1 - STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES William BRITT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 25 81</b>		2b. HOUR <b>940AM</b>	
1. SEX <b>male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 12, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hosp</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Miner</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD</b>		13b. COUNTY <b>Balto</b>	13c. CITY OR TOWN <b>Reisterstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Britt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA Crockett</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>167-05-2953</b>		17. INFORMANT ADDRESS <b>MRS. Margaret Britt same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electromechanical asystole</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic and Coronary Heart Disease</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>8/6/81</b> , 19 <b>8</b> , to <b>6/25</b> , 19 <b>8</b> , that (1) <del>was</del> last saw the deceased alive on <b>6/25</b> , 19 <b>8</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If (we) I did (did not) view the body after death.						
22b. SIGNATURE <b>Juan C. Ruffier MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/25/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JUAN C. RUFFIER</b>				22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 30, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lafayette Mem. Pk</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brier Hill Fayette PA.</b>
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck Inc. Baltimore, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>11/26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>MARVIN BROWN</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 6 3 19 81	
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR 6 10 48	6. AGE (IN YEARS LAST BIRTHDAY) <b>32 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 3 19 81		2b. HOUR <b>6:30</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>					
10. CITY OR TOWN OF DEATH <b>Fullerton</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>(auto) Belair &amp; Forge Rds.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Photographer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>		13b. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1613 Bakebury Ct.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Rodell Brown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Smith</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217 50 5974</b>		17. INFORMANT <b>Lillian Brown</b>				ADDRESS <b>1613 Bakebury Ct.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9650</b> IMMEDIATE CAUSE (a) <b>Gunshot wounds of head (handgun)</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>5:30 PM 6-3- 19 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject shot.</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>auto</b>		21i. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Belair &amp; Forge Rds., Fullerton, Balto., Md.</b>						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Ann M. Dixon, M.D.</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>6-3-81</b>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-9-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Mem. Pk.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Brown/Thompson F.H. 1913 W. Balto. St.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 9 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>History/Roby</b>					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

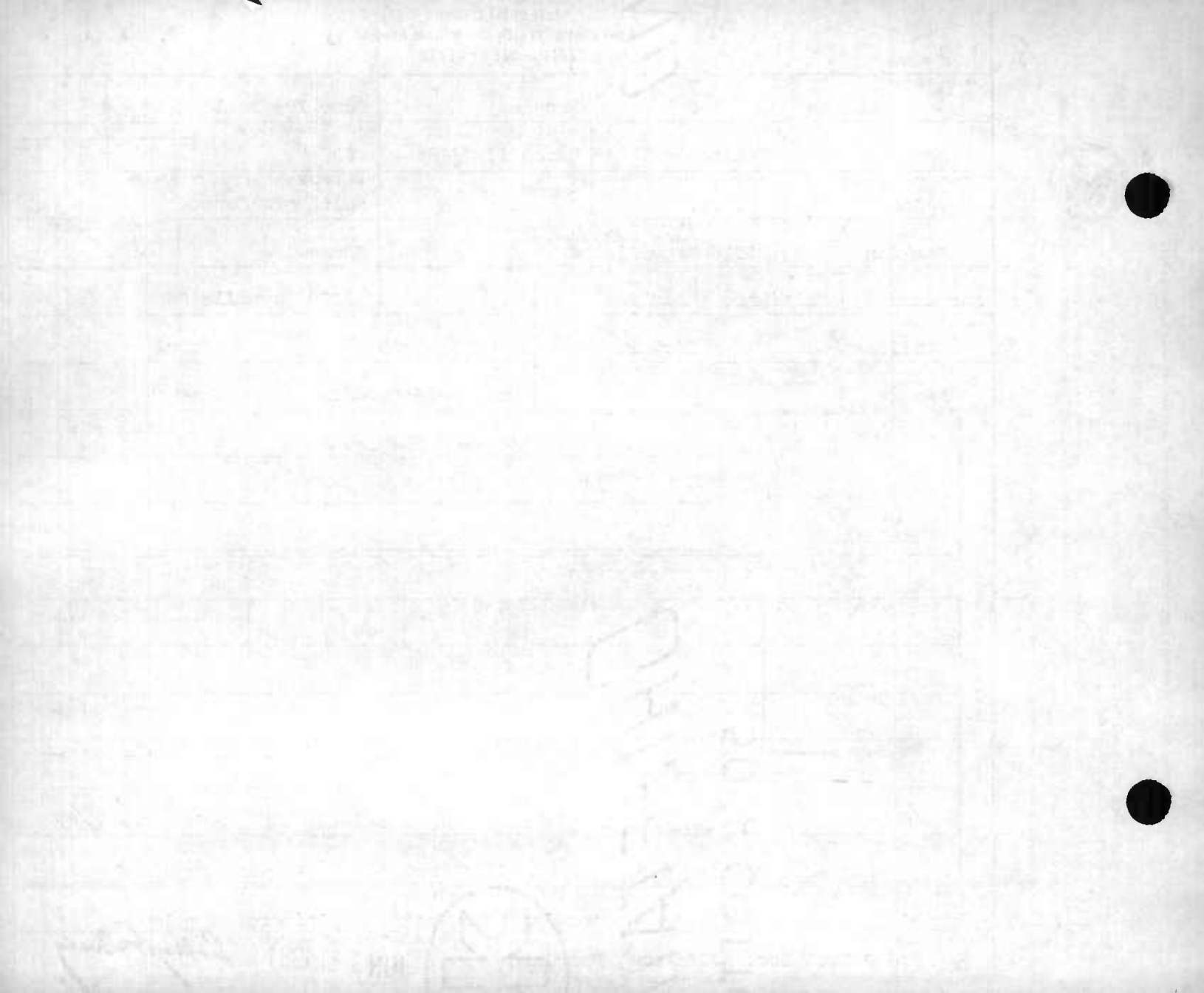
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		June 10, 1981		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		March 11, 1898		83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Parkton		1320 Rayville Rd		Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Baltimore		Parkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		1320 Rayville Rd			
William Ricker		Elizabeth Schul					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Mr Ronald Broyles		Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>SEPT 5, 1979</u> to <u>JUNE 9, 1981</u> , that (I) (we) last saw the deceased alive on <u>JUNE 8, 1981</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Roland C. Einhorn, MD						6/10/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Roland C Einhorn M.D.		1205 York Rd		Towson, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		6/13/81		Moreland Mem Park		Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland		JUN 11 1981		R. J. Ruck			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

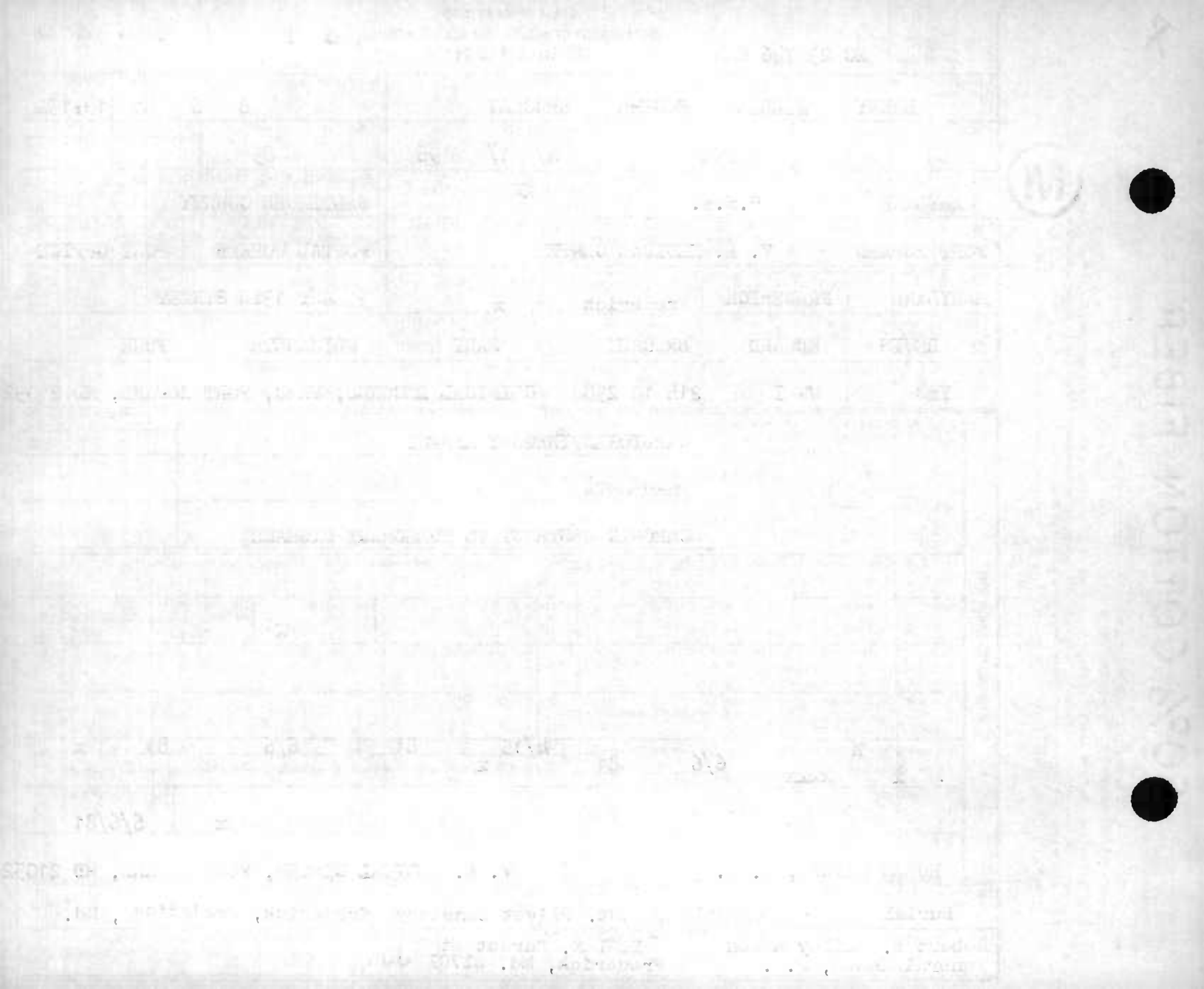


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	6	2	0
1- FOR STATE REGISTRAR XC 23 746 644										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>HARRY WILLIAM EUGENE BRUCHEY</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>6 6 81</b>				2b. HOUR <b>10:15A</b>		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4/ 1/ 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>						
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.										
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>V. A. MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POSTAL WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POST OFFICE</b>								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>FREDERICK</b>		13c. CITY OR TOWN <b>Frederick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5 EAST 13TH STREET</b>						
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEWIS EDWARD BRUCHEY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ELIZABETH FUNK</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WW 1 214 10 2588</b>		17. INFORMANT ADDRESS <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD 21052</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>4/15</b> , 19 <b>81</b> , to <b>6/6</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost <b>6/6</b> , 19 <b>81</b> , and that in <b>MD</b> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.																
22b. SIGNATURE <b>R. Reider MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6/6/81</b>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUBEN REIDER, M. D.</b>				22e. ADDRESS <b>V. A. MEDICAL CENTER, FORT HOWARD, MD 21052</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/9/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick, Frederick, Md.</b>								
24. FUNERAL DIRECTOR <b>Robert E. Dailey &amp; Son</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 10 1981</b>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>								
Funeral Homes, P.A.				Frederick, Md. 21701												





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 2 1

1 - FOR  
STATE  
REGISTRAR

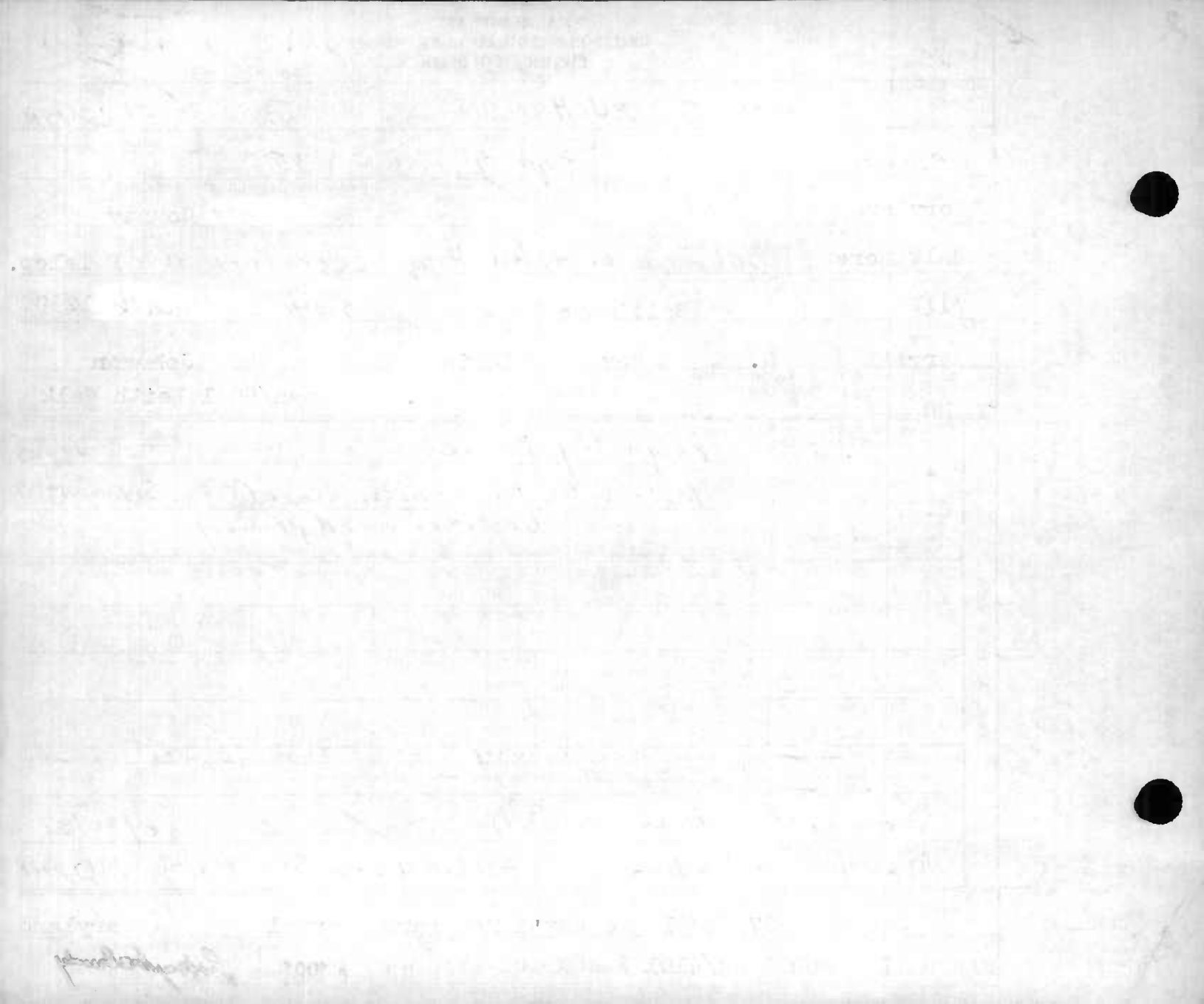
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SHARON J BUCHANAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 30 81</b>		2b. HOUR <b>22.15A</b>		
3. SEX <b>Female</b>		4. RACE- <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 4 1950</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telep.</b>		
10. CITY OR TOWN OF DEATH <b>Baltimore</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hosp.</b>				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>MD</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Merrill R. Roy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gloria Johnson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>212-56-5471</b>		17. INFORMANT ADDRESS <b>Robert A. Buchanan/5941 Leith Walk</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Adenocarcinoma of</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>undetermined primary</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Two weeks</b> <b>Six months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>January 19 81</b> to <b>June 30, 19 81</b> , that (I) (we) lost saw the deceased alive on <b>June 30, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Marshall A. Levine</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/30/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marshall A. Levine</b>				22e. ADDRESS <b>711 W. 40th St. Balto, MD, 21211</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>07/06/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md Nat'l Mem Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>MARSHALL W JONES JR/4101</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 1 4 6 2 2	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Ethel Bucheimer				2a. DATE OF DEATH MONTH DAY YEAR 06 14 81		2b. HOUR 11:00 <sup>a</sup> AM
3 SEX Female	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 11 05 92		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD		
10. CITY OR TOWN OF DEATH Catonsville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) House in the Pines Catonsville			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Henry Kirckoff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 213-05-9285		17. INFORMANT ADDRESS Virginia Powell, 1121 McAdoo Ave. Baltimore		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Vaginal Stenosis</i> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Vaginal Stenosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic Vaginal Stenosis</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 12-3-77		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6-14-81		
22a. I certify that (I) (this hospital) attended the deceased from 12-3-77 19 to 6-14-81 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Dr. George Angov</i>				DEGREE		22c. DATE SIGNED 4-15-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. George Angov				22e. ADDRESS 3350 Wilkens Ave., Baltimore, MD 21229		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/17/81		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.
24. FUNERAL DIRECTOR NAME Witzke Funeral Home				24b. ADDRESS 1630 Edmondson Ave.		25a. DATE REC'D. BY REGISTRAR JUN 16 1981
				25b. REGISTRAR'S SIGNATURE <i>Richard H. H. H.</i>		

12

BP

4013 Transdome Rd., Apt. 1-B

343-55-9202

Virginia Beach, VA 23462

Location Page

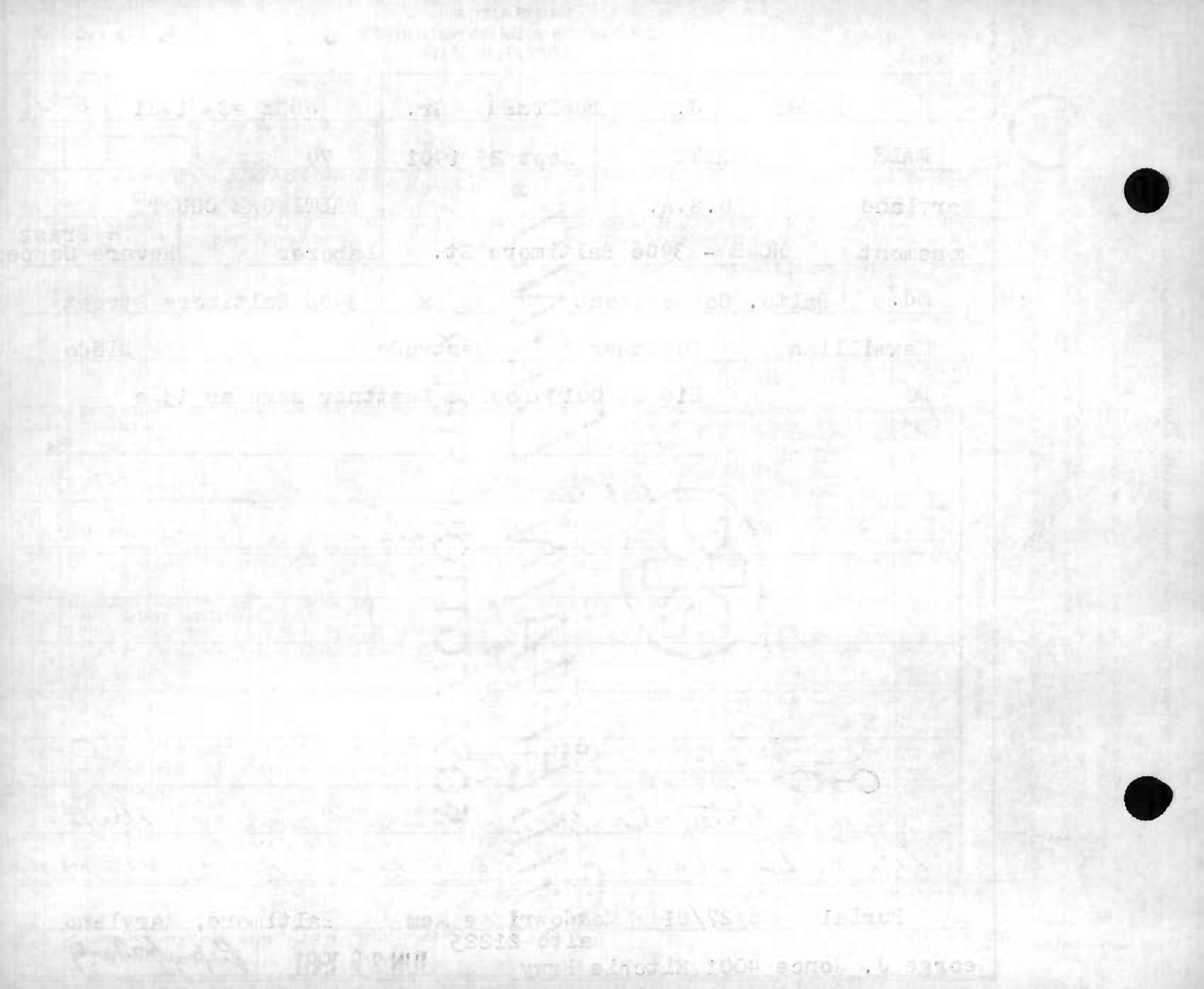
Index

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 6 2 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HENRY J. BUETTNER Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 24 1981</b>				2b. HOUR <b>5:00 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 25 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>79</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>Rosemont</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOME - 3906 Baltimore St.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Brass Revere Copper</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto. Co</b>		13c. CITY OR TOWN <b>Rosemont</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3906 Baltimore Street</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Maxmillian Buettner</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Diddo</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216 03 0013</b>		17. INFORMANT ADDRESS <b>Louise Buettner same as 13 e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Codexia</b> <b>1889</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Transitional cell bladder cancer</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>9 mo</b> <b>2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1980</b> , to <b>June 24, 1981</b> , that (I) (we) last saw the deceased alive on <b>6/17</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) and not view the body after death.											
22b. SIGNATURE <b>William C. Waterfield MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/24/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. C. WATERFIELD</b>				22e. ADDRESS <b>909 CACON AVE ST AGNES HOSP BALT 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hwy</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



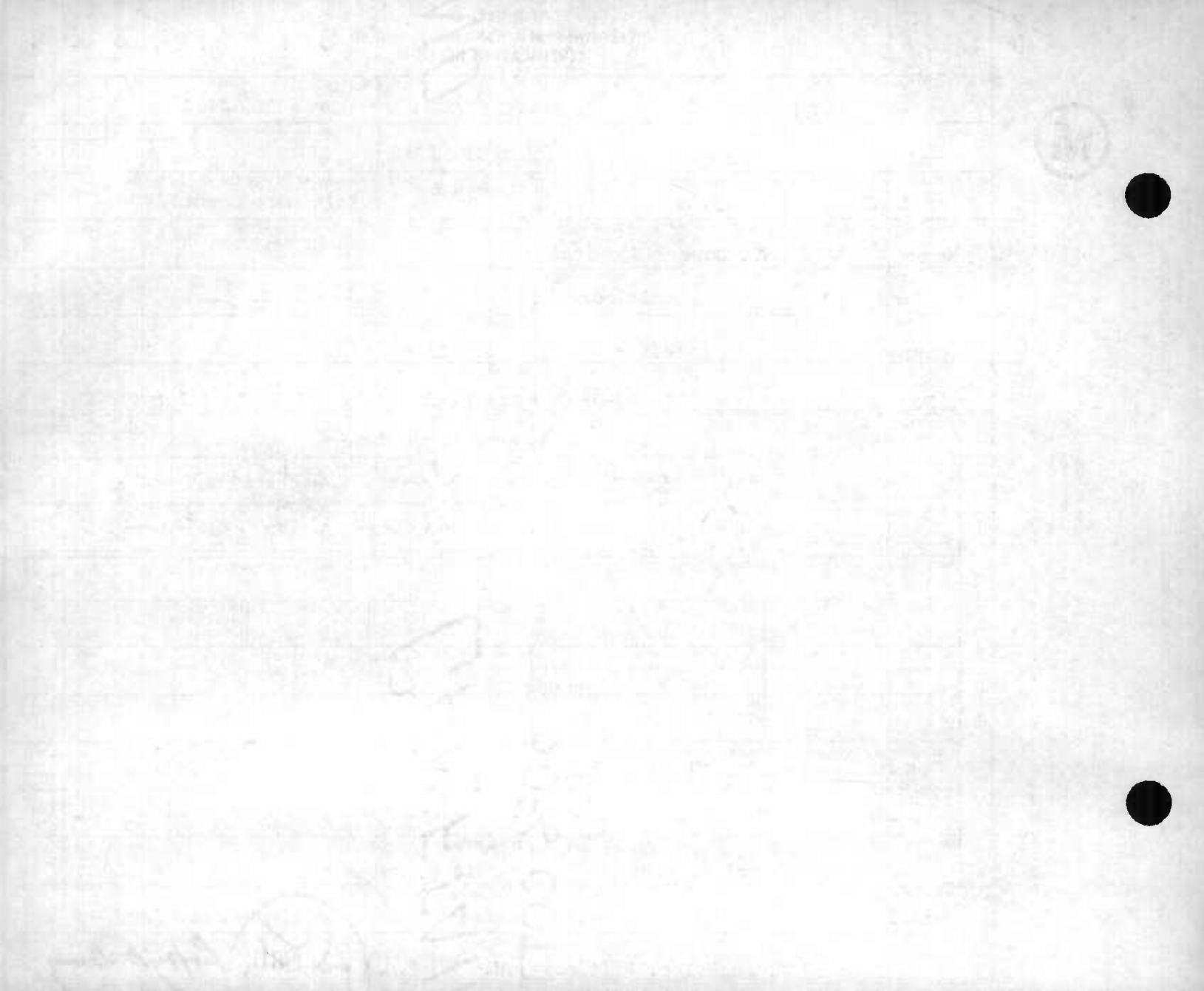


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8114624					
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)					3. SEX					4. RACE					
JOSEPHINE C BUETTNER					Female					White					
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)					7. IF UNDER 1 YEAR					
October 18, 1895					85					MONTHS DAYS HOURS MIN					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					9. BALTIMORE CITY OR COUNTY OF DEATH					10. CITY OR TOWN OF DEATH					
Maryland					Baltimore County, MD.					Towson					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					
St. Joseph Hospital					Housewife										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13b. CITY OR TOWN					13c. INSIDE CITY LIMITS?					
Maryland					Baltimore					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					
Conrad Pfeifer					Carolina ?					YES <input type="checkbox"/> NO <input type="checkbox"/>					
16b. SOCIAL SECURITY NO.					17. INFORMANT					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
218-52-3952					Mrs Elaine Schaedel					PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio genic shock</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute or chronic heart lesion.</u> (c) <u>acute myocardial infarction.</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION							
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/25/81 to 5/29/81, that (I) lost sight of the deceased alive on 5/25/81, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.															
22b. SIGNATURE				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Ruben S. Sebastian, M.D.				6/19/81				Ruben S. Sebastian, M.D.				2314 E. Joppa Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				6/22/81				Holy Redeemer				Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Leonard J. Ruck, Inc. Baltimore, Md.				JUN 22 1981				R. J. Ruck							



FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Michael Edward Bunch</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 28, 1981</b>			2b. HOUR <b>6:40 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8-21-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5740 Cedonia Ave.-21206</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Charles Bunce</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret C. Mil Michael</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-07-4370</b>		17. INFORMANT ADDRESS <b>Mrs. Mary F. Bunch - 5740 Cedonia Ave.-21206</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4273</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rapid Atrial Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <b>Chronic Obstructive Pulmonary Disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <b>June 25</b> , 19 <b>81</b> , to <b>June 28</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>June 28</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Nestor Carmona</i>				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>June 29, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Nestor Carmona, M.D.</b>				22e. ADDRESS <b>7620 York Rd., Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7-1-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

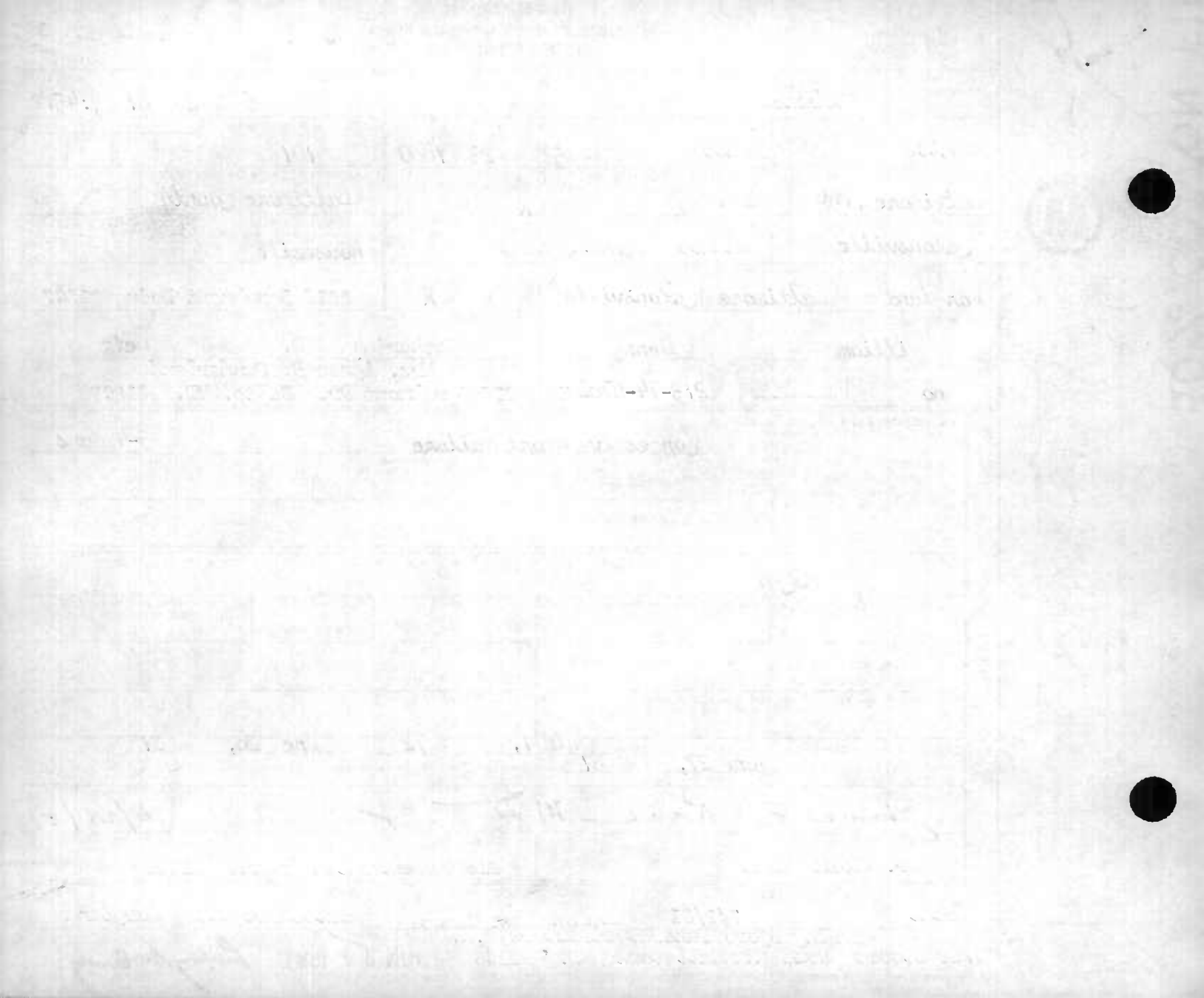
1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Florence Busey</i>			2b. DATE OF DEATH MONTH DAY YEAR <i>6 28 81</i>		2b. HOUR <i>9:45 P M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 23 1880</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>101</i> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore, MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Catonsville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Summit Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <i>Maryland</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Woodlawn</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>2615 Larchmont Drive 21207</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Penny</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine D. Detz</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-07-3595D</i>		17. INFORMANT <i>Mrs. Agnes B. Sunderland</i> <i>2615 Larchmont Dr. Balto. MD. 21207</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4280 Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-4 days</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>ASCVD</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>July 1, 19 72</i> to <i>June 28, 19 81</i> , that (I) (we) last saw the deceased alive on <i>June 27, 19 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>James E Rowe</i> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>6/29/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. James Rowe</i>			22e. ADDRESS <i>413 Commonwealth Avenue 21228</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>7/1/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i>					
24. FUNERAL DIRECTOR <i>Loring Byers Funeral Directors, P.A.</i> <i>8728 Liberty Road Randallstown, MD. 21133</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 30 1981</i>	
				25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR				REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret S Calary</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 9, 1981</b>			2b. HOUR <b>7:45A</b> M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept 8, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Valley View Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>? Sacrey</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>? Diefel</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-74-1855</b>		17. INFORMANT ADDRESS <b>Mr William Calary</b>			Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>stroke with @ hemiplegia</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DOE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DOE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>6/8/81</b> to <b>6/9/81</b> that (I) (we) last saw the deceased alive on <b>6/8/81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE <b>Vuong Vu Nguyen M.D.</b>				22b. ADDRESS <b>1656 E. Belvedere Ave Baltimore, Maryland</b>				22c. DATE SIGNED <b>6/9/81</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/11/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McBrady</b>			

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No	212-74-1852	Mr William Calary	Same
?	Sacrey	?	Diesel
	Baltimore	x	1942 Mountain Ave
	Parkville		

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 2 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Harry Gilbert Campbell</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6 1 81</i>		2b. HOUR <i>3:05</i> P. M.
3. SEX <i>MALE</i>	4. RACE <i>WHITE</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 25 99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Rossville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MANOR CARE Rossville</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth. Steel</i>
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Eastpoint</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Thomas Marion Campbell</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Edith Orbell</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-09-3470</i>		17. INFORMANT ADDRESS <i>Edith Hoffman 6530 Conkley Rd. 21237</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Terminal Ca of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) (this hospital) attended the deceased from <i>5/14</i> , 19 <i>79</i> , to <i>6/1</i> , 19 <i>81</i> , that (b) (we) lost saw the deceased alive on <i>5/7</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>N. Haroun</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/1/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NAJJI J. HAROUN</i>		22e. ADDRESS <i>9101 Franklin Sq. Dr. Balto. 21237</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-4-81</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>7225 Eastern Blvd. Balto., Md.</i>
24. FUNERAL DIRECTOR NAME <i>C.S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>6224 Eastern Ave. 21224</i>		25a. DATE REC'D. BY REGISTRAR <i>JUN 3 1981</i>	25b. REGISTRAR'S SIGNATURE <i>L. J. Brady</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 2 9

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maurice M. Murphy Carroll Sr			2a. DATE OF DEATH MONTH DAY YEAR June 7 81		2b. HOUR 7:15A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5-4-1897	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech Eng		12b. KIND OF BUSINESS OR INDUSTRY U.S.gov
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 701 Murdock Rd 21212	
14. FATHER'S NAME FIRST MIDDLE LAST William Joseph Carroll		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Murphy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 218-22-0404A		17. INFORMANT ADDRESS Kathryn F. Carroll 701 Murdock Rd 21212	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 5 19 81, to June 7 19 81, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 7 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE Robert E. Stoner		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6-7-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert E. Stoner		22e. ADDRESS 714 York Rd Towson 4204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-9-81		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem Gar	
23d. LOCATION CITY OR TOWN COUNTY STATE Lutherville Balto Md		24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedegeld Home 6500 York Rd 21212			
25a. DATE REC'D. BY REGISTRAR JUN 10 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar of Death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 6 3 0									
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR			
Charles D. Cayce JR.						June 18, 1981										5:05PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE		WHITE		AUGUST 2, 1916		64 YRS.				MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
MARYLAND		U.S.A.				Baltimore County										MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Towson		St. Joseph Hospital						GENERAL				BLACK + Decker							
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
MD.						BALTO.		PARKVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3326 EAST JOPPA ROAD							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
Charles D. Cayce, Sr.						VIRGIE						GRIFFITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS											
NO						217 07 2450		FAMILY RECORDS											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arrhythmia, secondary severe coronary</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerosis and recent myocardial</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>infarction.</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Emphysema.</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>6/8</u> , 19 <u>81</u> , to <u>6/18</u> , 19 <u>81</u> , that <del>the</del> (we) last saw the deceased alive on <u>6/18</u> , 19 <u>81</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) (did) (did not) view the body after death.																			
22b. SIGNATURE						DEGREE						22c. DATE SIGNED							
<u>Henry S. Crist, M.D.</u>												6-19-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS													
Henry S. Crist, M.D.						7620 York Road, Towson, MD 21204													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL				6-22-1981		Moreland Mem. PK.				PARKVILLE BALTO. MD.									
24. FUNERAL DIRECTOR NAME ADDRESS																25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
EVANS Funeral Chapel 8800 Harford Rd.																JUN 26 1981		<u>Henry S. Crist</u>	

MEDICAL CERTIFICATION

19

BP



NOT RECORDED





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death occurs at home, the death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>ELOISE M. CHRISTHILF</b>					2a. DATE OF DEATH MONTH <b>6</b> DAY <b>30</b> YEAR <b>81</b>			2b. HOUR <b>4 a.m.</b>		
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>7</b> DAY <b>8</b> YEAR <b>98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Eugene</b> MIDDLE <b>W.</b> LAST <b>Mac Neal</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Agatha</b> MIDDLE <b>L.</b> LAST <b>Devereux</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220 44 4543</b>		17. INFORMANT ADDRESS <b>Bryson G. Christhilf, Sr., Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6/29</b> , 19 <b>81</b> , to <b>6/30</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/30/81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ronald M.D.</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <b>6/30/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Sirota, M.D.</b>					22e. ADDRESS <b>6701 N. Charles St, Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION CITY OR TOWN <b>Pikesville,</b> COUNTY <b>Md.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#16b. Fm. 556, 6/23/81 by Wife, Obj.										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 3 2																																																	
1- FOR STATE REGISTRAR										CERTIFICATE OF DEATH										REG. NO.																																																	
1. DECEASED NAME (TYPE OR PRINT) JAMES B. CLARK										2a. DATE OF DEATH MONTH 6 DAY 13 YEAR 81										2b. HOUR M																																																	
3. SEX MALE										4. RACE BLACK										5. DATE OF BIRTH MONTH 3 DAY 25 YEAR 27										6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.										7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.										7. IF UNDER 24 HRS. HOURS MIN.																			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA										9. CITIZEN OF WHAT COUNTRY? USA										10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.										12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																			
13. CITY OR TOWN OF DEATH TOWSON										14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. JOSEPH HOSPITAL										15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										16. STREET ADDRESS 4807 HERRING RUN DR.										17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO. 13c. CITY OR TOWN										18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										19. STREET ADDRESS 4807 HERRING RUN DR.									
20. FATHER'S NAME FIRST James MIDDLE S. LAST Clark										21. MOTHER'S MAIDEN NAME FIRST Serressie MIDDLE LAST Tibbs										22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES										23. SOCIAL SECURITY NO. 124-20-1066										24. INFORMANT ADDRESS Barbara Clark 4807 Herring Run Dr.										25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) DIABETES PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) DIABETES										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
26. DATE OF OPERATION										27. CONDITION FOR WHICH OPERATION WAS PERFORMED										28. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										31. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19										32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
33. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>										34. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)										35. LOCATION STREET CITY OR TOWN COUNTY STATE										36. I certify that (I) (this hospital) attended the deceased from 3/14 19 74, to 6/13 19 81, that (I) (we) lost saw the deceased alive on 3/31 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										37. SIGNATURE M. M. MENENDEZ, M.D.										38. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										39. DATE SIGNED 6/18/81									
40. PHYSICIAN'S NAME (TYPE OR PRINT) M. M. MENENDEZ, M.D.										41. ADDRESS 5820 YORK RD BALTO. MD 21212										42. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										43. DATE 6/19/81										44. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.										45. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD																			
46. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Ave.										47. DATE REC'D. BY REGISTRAR JUN 19 1981										48. REGISTRAR'S SIGNATURE Pietro McCreedy										49. DHHH-16 30M 2/80 (VRA 15, 4)																																							



JAMES

CLARK

BLACK

BALTIMORE COUNTY

ST. JOSEPH HOSPITAL

TOMSON

BALTO.

ME.

PROV. WEIRING EMB. CO.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

51 14633

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HENRY C. CLODI			2a. DATE OF DEATH MONTH DAY YEAR June 22, 1981		2b. HOUR 5:10 P.M.						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 18, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Employment Agency			
13a. STATE Maryland		13b. COUNTY BALTO.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 508 Overbrook Road			
14. FATHER'S NAME FIRST MIDDLE LAST Louis Clodi				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Christine Moser							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 03 9629		17. INFORMANT Mrs. Edna E. Clodi				ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 5070 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Bilateral pneumonia (aspiration) (c) DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 7, 1981, to June 22, 1981, that I (we) last saw the deceased alive on June 22, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (and not) view the body after death.											
22b. SIGNATURE Friedrich						DEGREE MD		22c. DATE SIGNED 6/22/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Friedrich						22e. ADDRESS 9000 Franklin Square Dr., 21237					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/25/81		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212						25a. DATE REC'D. BY REGISTRAR JUN 26 1981		25b. REGISTRAR'S SIGNATURE L. J. Jenkins			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

No. 219-03-9029 Mrs. E. E. Cloyd  
 Cloyd  
 Christian  
 500 Overbrook Rd.  
 Baltimore, Md.  
 From the Bureau of  
 USA  
 July 13, 1952  
 C. CLOYD  
 HENRY

400 York Road, Baltimore, Md. 21212  
 Henry W. Johnston & Son Co.  
 Baltimore, Md.  
 7/13/52

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA ELLA COATES			2a. DATE OF DEATH MONTH DAY YEAR 6 15 81			2b. HOUR M				
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 15 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS # UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16 Winter Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. STATE MARYLAND			13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BALTIMORE CO. MD 21223 16 Winter Ave. Catonsville, md	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph SAVOY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nattie MATTHEWS			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				
16b. SOCIAL SECURITY NO. 213-03-8843B			17. INFORMANT ADDRESS Rev. Ridgley W. Coates Catonsville, md 21223 16 Winter Ave							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD m. I 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Ess. Hypertension (c) ANEMIA DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1965				
22a. I certify that (I) (this hospital) attended the deceased from 2 months ago, to 1965, that (I) (we) last saw the deceased alive on 2 months ago, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W. N. Iglecia						DEGREE M.D.			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. N. IGLECIA						22e. ADDRESS 411 MELVIN AVENUE				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6-18-81		23c. NAME OF CEMETERY OR CREMATORY Western Star Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MD		
24. FUNERAL DIRECTOR NAME Herbert E. Nutter						ADDRESS BALTO MD 21216 3035 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR JUN 16 1981		

MEDICAL CERTIFICATION

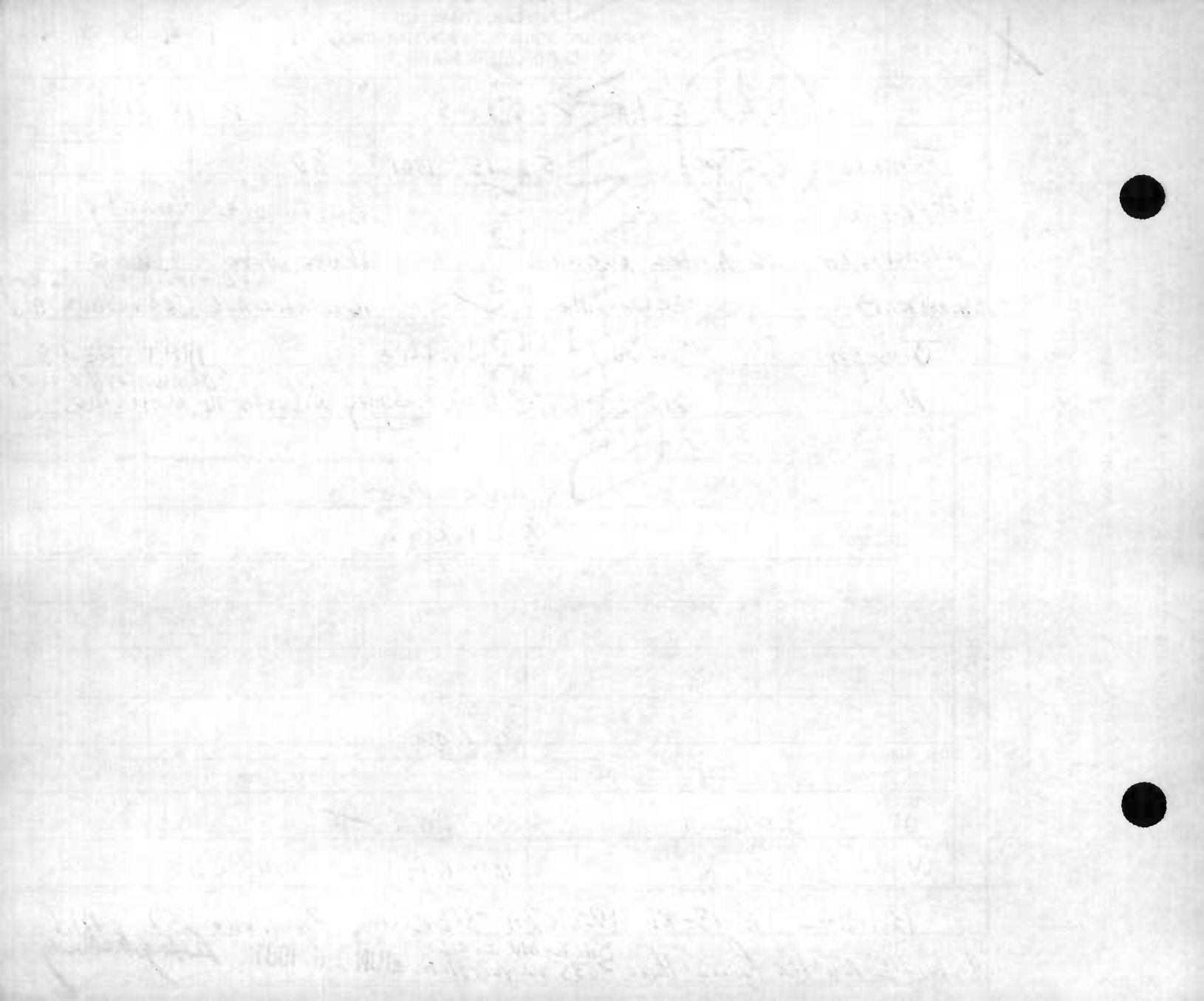
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14635					
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE COLLISON LAST COCKLIN										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 6 26 19 81		7b. HOUR M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 8, 1952		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 27 19 81		7d. HOUR M 6:20P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Richmond Va.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Reisterstown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS) 12366 Bonfire Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Employed at Westinghouse Corp.				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12366 Bonfire Drive							
14. FATHER'S NAME FIRST ROBERT MIDDLE F. LAST COCKLIN						15. MOTHER'S MAIDEN NAME FIRST RUTH MIDDLE CASTNER LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 225-64-1720		17. INFORMANT ADDRESS Mr. Robert F. Cocklin Arlington Va.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3071 IMMEDIATE CAUSE (a) Anorexia Nervosa Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER				DATE SIGNED 6/28/81	
ACTUAL SIGNATURE H. R. Guard															
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn Street, Balto., MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 29, 81		23c. NAME OF CEMETERY OR CREMATORY Westview Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.							
24. FUNERAL DIRECTOR Eline Funeral Home Reisterstown, Md. 21136						25a. DATE REC'D. BY REGISTRAR JUN 30 1981		25b. REGISTRAR'S SIGNATURE							

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David C. Reardon, Jr.

Dr. Robert E. Gossin, Washington VA

Operation June 27, 2007

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

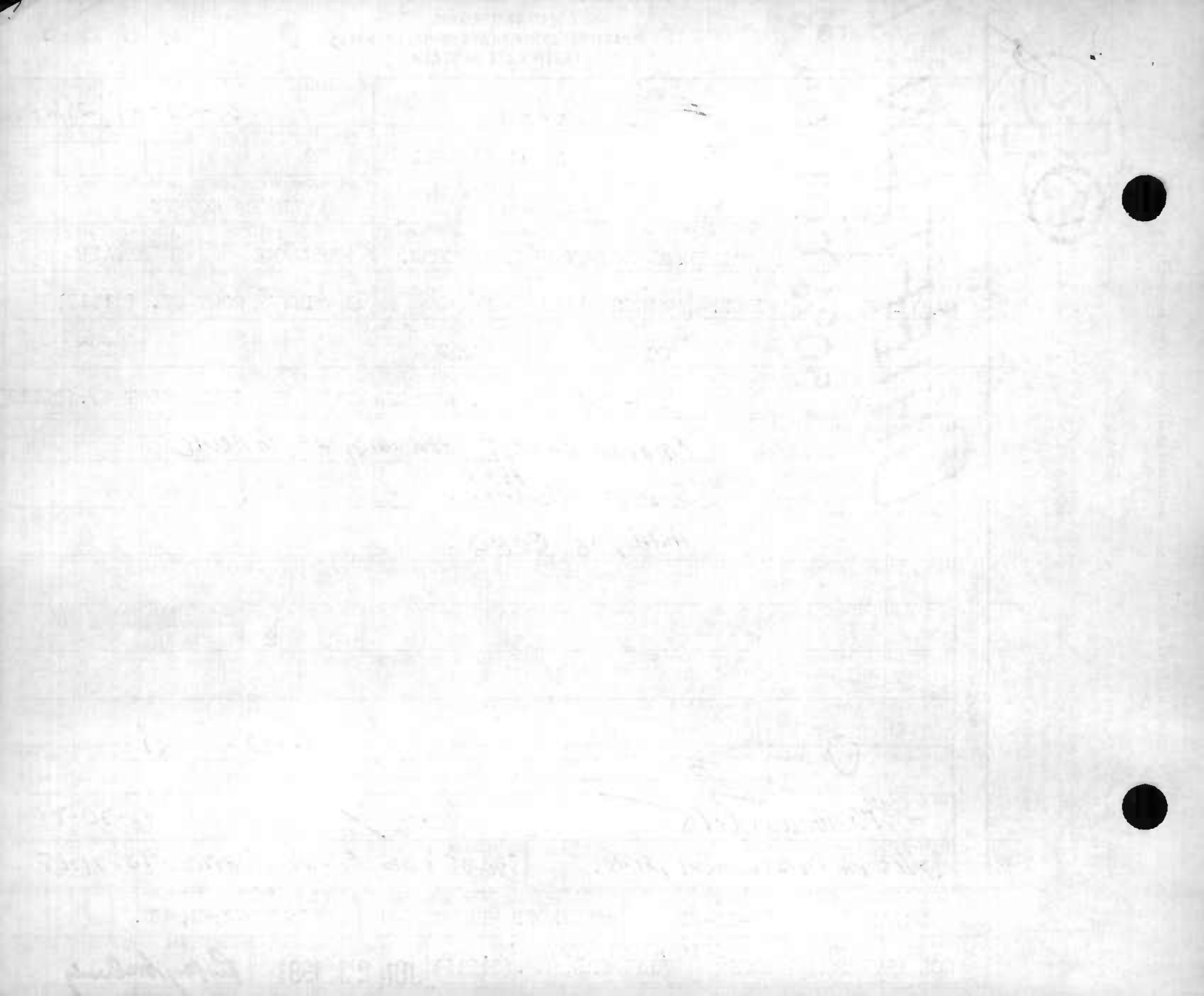
1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Samuel</b> <b>E</b> <b>Cohen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-20-81</b>		2b. HOUR <b>2:12 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 11, 1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BALTIMORE, MD.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTIMORE</b>	13c. CITY OR TOWN <b>OWINGS MILLS</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LEVI</b> <b>COHEN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>LENA</b> <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-01-4091</b>		17. INFORMANT ADDRESS <b>MRS. REBECCA COHEN 6E BITTER ROOT CT. (21117)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Cardiac Arrest probably 20 to 40 sec</b> DUE TO, OR AS A CONSEQUENCE OF <b>M.I.</b> (b) <b>Severe Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>History of COPD</b> (c) <b>History of COPD</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6-20-81</b> to <b>6-20-81</b> , that (I) (we) last saw the deceased alive on <b>6-20-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Joseph Deckerbaum, M.D.</b>		DEGREE		22c. DATE SIGNED <b>6-20-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH DECKERBAUM, M.D.</b>		22e. ADDRESS <b>3635 OLD CT. RD. BALTO. MD. 21205</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-21-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE HEBREW CEM</b>	
23d. LOCATION <b>REISTERSTOWN, MD.</b>		23e. STATE <b>MD.</b>		23f. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>	
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS</b>		6010 REISTERSTOWN RD. <b>BALTIMORE, MD. (21215)</b>		25b. REGISTRAR'S SIGNATURE <b>Jeffrey A. Brady</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	6	3	7
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) GEORGE COLLINS										2a. DATE OF DEATH MONTH DAY YEAR HOUR 6 15 81 3 50 P.M.						
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 1 1901		6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS 3		IF UNDER 24 HRS. HOURS MIN. 3						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ROMANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO County MD.										
10. CITY OR TOWN OF DEATH BALTIMORE MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELLA MARIS Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Jockey		12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3104 Spaulding Ave								
14. FATHER'S NAME FIRST MIDDLE LAST George COLLINS				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SAUENA Unknown												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-03-0662		17. INFORMANT ADDRESS STELLA MARIS Hospice - Dulaney Rd.										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4380 BILATERAL ASPIRATION pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) OLD Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Dr. Eddie Nakhuda				DEGREE				22c. DATE SIGNED 6/15/81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Eddie Nakhuda				22e. ADDRESS STELLA MARIS Hospice												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/19/81		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland								
24. FUNERAL DIRECTOR Ruck Towson Funeral Home, Inc.						ADDRESS 1050 York Road		25a. DATE REC'D. BY REGISTRAR JUN 17 1981		25b. SIGNATURE						





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

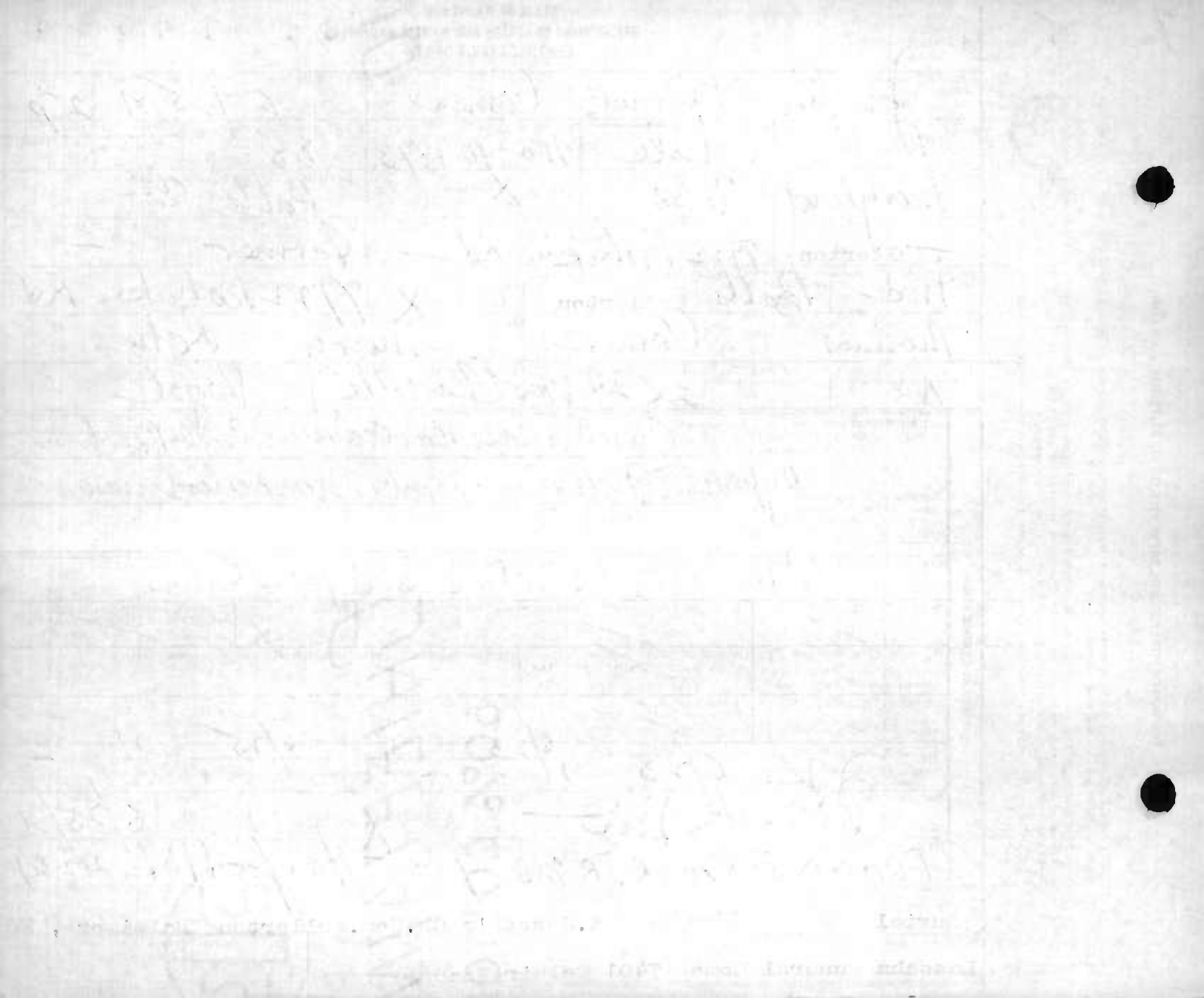
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Joseph Marshall Comes</i>			2a. DATE OF DEATH MONTH <i>6</i> DAY <i>25</i> YEAR <i>81</i>			7a. HOUR <i>2<sup>30</sup></i> M					
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>Mar</i> DAY <i>10</i> YEAR <i>1893</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>		7b. HOUR <i>2<sup>30</sup></i> M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Balto Co.</i> MD.		
10. CITY OR TOWN OF DEATH <i>Fullerton</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4111 Babekow Rd</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>			12b. KIND OF BUSINESS OR INDUSTRY —		
13a. STATE RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE ADDRESS BEFORE ADMISSION) <i>Md</i>			13b. COUNTY <i>Balto</i>			13c. CITY OR TOWN <i>Fullerton</i>			13d. STREET ADDRESS <i>4111 Babekow Rd</i>		
14. FATHER'S NAME FIRST <i>Thomas</i> MIDDLE <i>—</i> LAST <i>Comes</i>			15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>Rohe</i> LAST <i>—</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE UNKNOWN)			16b. SOCIAL SECURITY NO. <i>215 24 840</i>		
17. INFORMANT NAME <i>Charlotte Vogel</i> ADDRESS <i>—</i>			18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Occlusion Cerebral Ischemia</i> <i>4349 Hypertensive or as a consequence of</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Vascular Disease</i> (c) <i>—</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>—</i>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. <i>Previous strokes and paralysis</i>		
19a. DATE OF OPERATION <i>6/23</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <i>—</i> A.M. MONTH <i>6</i> DAY <i>23</i> YEAR <i>81</i> P.M. <i>—</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>—</i>			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>—</i>		
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f. LOCATION STREET <i>—</i> CITY OR TOWN <i>Fullerton</i> COUNTY <i>Balto</i> STATE <i>Md</i>			21g. LOCATION STREET <i>—</i> CITY OR TOWN <i>Fullerton</i> COUNTY <i>Balto</i> STATE <i>Md</i>			21h. LOCATION STREET <i>—</i> CITY OR TOWN <i>Fullerton</i> COUNTY <i>Balto</i> STATE <i>Md</i>		
22a. I certify that (i) (this hospital) attended the deceased from <i>6/23</i> 19 <i>81</i> to <i>6/25</i> 19 <i>81</i> and that in my opinion death occurred on the date and hour and from the causes stated above. (If death did not occur, the body after death)			22b. SIGNATURE <i>Frank T. Kasik Jr MD</i>			22c. DEGREE <i>MD</i>			22d. DATE SIGNED <i>6/25/81</i>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>FRANK T. KASIK JR MD</i>			22f. ADDRESS <i>9005 Harford Rd 21234</i>			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>6/29/81</i>		
23c. NAME OF CEMETERY OR CREMATORY <i>St. Joseph's Ch. Cem.</i>			23d. LOCATION CITY OR TOWN <i>Fullerton</i> COUNTY <i>Baltimore</i> STATE <i>Md</i>			24. FUNERAL DIRECTOR NAME <i>Lassahn Funeral Home</i> ADDRESS <i>7401 Belair Road</i>			25a. DATE REC'D BY REGISTRAR <i>JUN 29 1981</i>		
25b. REGISTRAR'S SIGNATURE <i>—</i>			25c. REGISTRAR'S SIGNATURE <i>—</i>			25d. REGISTRAR'S SIGNATURE <i>—</i>			25e. REGISTRAR'S SIGNATURE <i>—</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR a	
Josephine Mary CONRAD								June 23, 1981		4:30 M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		March 11 1892		88 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md.		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Franklin Square Hospital						Homemaker		--	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.				Balto.				4004 Raymonn Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Anthony Dvorak				Barbara --							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no		212-74-8733		Dorothy O'Keefe (dghtr) same address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 4375 DUE TO, OR AS A CONSEQUENCE OF (b) <u>General Debilitation and Mental Depression</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <u>June 20</u> , 19 <u>81</u> , to <u>June 23</u> , 19 <u>81</u> , that (we) lost saw the deceased alive on <u>June 23</u> , 19 <u>81</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (and) (our) view the body after death.											
22b. SIGNATURE <u>Diane Lowe</u> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>6/23/81</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Diane Lowe M.D.</u>						22e. ADDRESS <u>9000 Franklin Square Drive 21237</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>6/26/81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION CITY OR TOWN <u>Balto.</u> COUNTY <u>Md.</u>					
24. FUNERAL DIRECTOR <u>Schumnek Funeral Home, Inc.</u>						25. DATE REC'D. BY REGISTRAR <u>JUN 24 1981</u>		25a. REGISTRAR'S SIGNATURE <u>History McCreedy</u>			
3331 Brehms Lane, Balto. Md. 21213											



WORLD-WIDE  
PUBLICATIONS



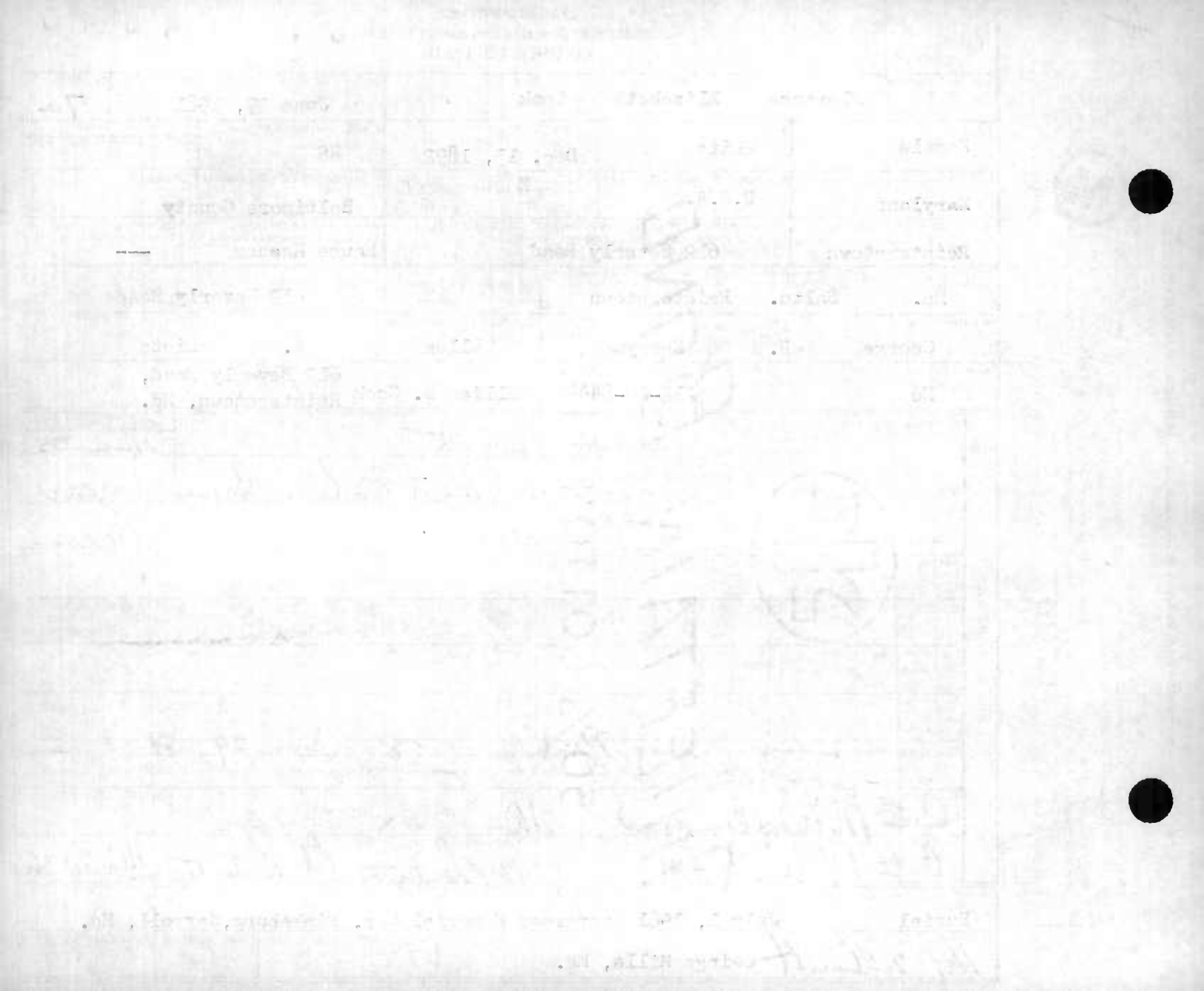
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 4 0		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Elizabeth Cook					2a. DATE OF DEATH MONTH DAY YEAR June 29, 1981				2b. HOUR 7a <sup>AM</sup>			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Reisterstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 612 Beverly Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Keeper			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.					13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 612 Beverly Road	
14. FATHER'S NAME FIRST MIDDLE LAST George H. Merryman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen A. Dietz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 212-20-8444		17. INFORMANT ADDRESS 612 Beverly Road, Reisterstown, Md. William B. Cook					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>1 year</u> <u>Years</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from <u>March 10</u> , 19 <u>58</u> , to <u>June 29</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>June 25</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE C.E. McWilliams MD.						DEGREE MD.			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams						22e. ADDRESS 1904 Reisterstown Rd., Reisterstown Md. 21136						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE July 1, 1981		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gar.			23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.			
24. FUNERAL DIRECTOR NAME H. E. Ehlhardt						ADDRESS Swings Mills, Md.			25a. DATE REC'D. BY REGISTRAR JUL 2 1981			
						25b. REGISTRAR'S SIGNATURE						





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with information after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by date.

BP

DHMH-16 30M 2/80  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER TAYLOR COOK			2a. DATE OF DEATH MONTH DAY YEAR JUNE 10, 1981			2b. HOUR M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV. 14, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MT. WILSON LANE BOX 235				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY QUARRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTIMORE 13c. CITY OR TOWN PIKESVILLE					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MT. WILSON LANE		
14. FATHER'S NAME FIRST MIDDLE LAST WALTER SCOTT COOK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA BOYD GAINOR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 052-22-9431		17. INFORMANT ADDRESS ANNE BOWEN COOK BOX 235 MT. WILSON LA. 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon with metastases</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>January</u> , 19 <u>81</u> , to <u>June 10</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/9</u> , 19 <u>81</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. Myrton Gaines Jr.</u> MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/10/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. MYRTON GAINES JR.				22e. ADDRESS 7800 YORK RD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JUNE 12, 81		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.			23d. LOCATION CITY OR TOWN COUNTY STATE PIKESVILLE BALTIMORE MD.		
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL-WIEDEFELD HOME 6500 YORK RD. 21212				25a. DATE REC'D. BY REGISTRAR JUN 16 1981			25b. REGISTRAR'S SIGNATURE		

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and signed by.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 4 2	
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
KATHERINE COUGHLIN				June 16, 1981	
3. SEX F		4. RACE W		2b. HOUR 6:40a M	
5. DATE OF BIRTH SEPT. 5, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE M.D.		13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN BETZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET MILLER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 212 22 3839		17. INFORMANT ADDRESS LAWRENCE COUGHLIN ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recent left Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 21, 19 81, to June 16, 19 81, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive or above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE Ronald Friedman MD	
22c. DATE SIGNED 6-16-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald Friedman		22e. ADDRESS 9000 Franklin Square Drive 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/19/81		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN	
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD		24. FUNERAL DIRECTOR NAME J.G. CONNELLY ADDRESS 300 MACE		25a. RECEIVED BY REGISTRAR JUN 22 1981	
25b. REGISTRAR'S SIGNATURE R. J. McElroy					

BP



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 4 3			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Dallas PARROTT Crandell</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6/1/81 06 01 81</b>		2b. HOUR <b>10:30A M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 10 90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>House in the Pines Catonsville</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>A.A. Co.</b>		13c. CITY OR TOWN <b>Brooklyn</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Crandell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lida Dawson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b> <b>W.W.I</b>			
17a. SOCIAL SECURITY NO. <b>216-07-0910</b>		12. INFORMANT ADDRESS <b>John D. Crandell same as 13 e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>4273</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atrial Fibrillation</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>1 yr.</b> <b>2 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19 81</b> , to <b>June 1 81</b> , that (I) (he) last saw the deceased alive on <b>May 29 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) (did not) view the body after death.							
22b. SIGNATURE <b>David R. Moseman, M.D.</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-2-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. David Moseman</b>				22e. ADDRESS <b>4713 Leeds Avenue, Baltimore, Md. 21227</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>George J. Gonce 4001 Ritchie Hgwy</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 5 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Ruby McBrady</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD RAYMOND CROWL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 20 1981</b>		2b. HOUR <b>6:25 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 12, 1889</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.						
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist</b>		
12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						
13a. STATE <b>Maryland</b>		13b. COUNTY		13c. CITY OR TOWN <b>Baltimore</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1151 Riverside Ave.</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter E. Crowl</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alta J. Riker</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-01-4859</b>		17. INFORMANT ADDRESS <b>600 Brisbane Rd. Irvin J. Crowl, Sr. Balto., Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b>						
DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA</b>						
DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>6-12</b> , 19 <b>81</b> , to <b>6-20</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-20</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/20/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 23, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Glen Haven, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. Balto. Md.</b>				

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR dad 18, 21a & 22a 7/15/81 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										1 4 6 4 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Andrew Culotta</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>June 17 1981</b>		2b. HOUR <b>7:30 AM</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>3-27-99</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>82 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>0 0</b>	IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>	2c. DATE PRONOUNCED DEAD <b>June 17 1981</b>		2d. HOUR <b>7:30 AM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Argentina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles St. 21204</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Industrial Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5213 Harford Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carmelo Culotta</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Fava</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-10-9776</b>		17. INFORMANT ADDRESS <b>Marie A. Culotta, 5213 Harford Rd.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-Respiratory Failure</b> 0000 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) <b>Fracture of Left Hip</b> Correct 4 Days DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized ASCVD</b> 5 1/2 yrs											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Correct</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6:30 P.M. June 13 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Fell at Home</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>5213 Harford Rd. Balto. Co. Md.</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . <b>Correct</b>											
ACTUAL SIGNATURE <b>Richard J. O'Connell</b>				TITLE (SPECIFY) <b>M.D. Deputy</b>				DATE SIGNED <b>6/17/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-18-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Richard J. O'Connell</b>			

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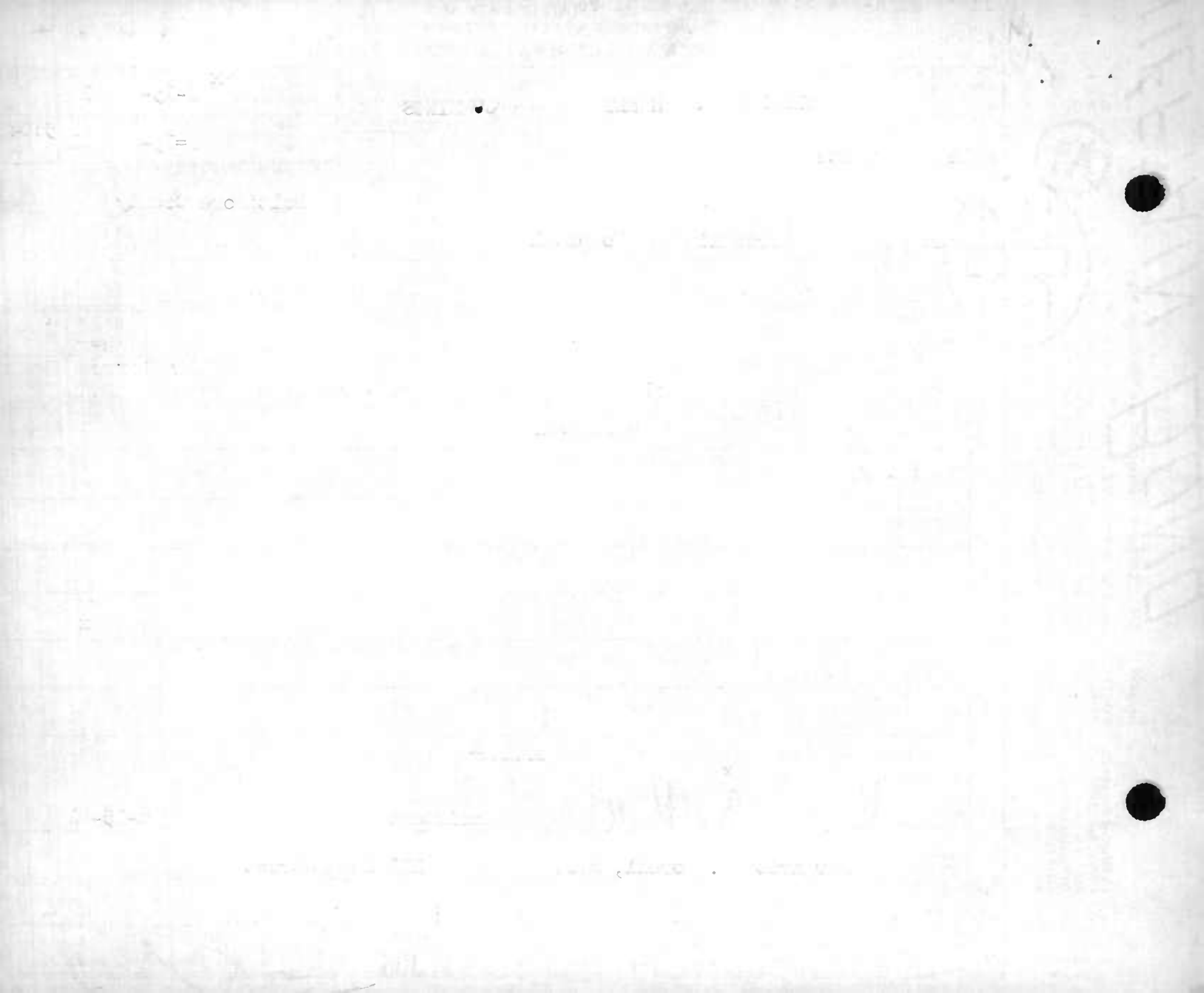


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17  
(VR A15 ME (5))  
15M 2/80

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM HENRY CUMMINGS, Sr.</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> <b>6-15-81</b>		2b. HOUR <b>81</b>		2c. DATE PRONOUNCED DEAD <b>6-15-81</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 5 44</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>37</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
10. CITY OR TOWN OF DEATH <b>Rossville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Iron Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Local #16</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles K. DeBrick</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann M. Bahen</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-40-6628</b>		17. INFORMANT ADDRESS <b>Susan M. Cummings Essex, MD. 21221</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>3049</b> IMMEDIATE CAUSE (a) <b>Narcotism</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Margareta A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6-16-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>				23b. DATE <b>6/19/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. R. Ruck</b>			
7922 Wise Avenue Dundalk, MD. 21222											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

Item #5 Film G557 7/6/81 re

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 4 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BESS S DAUB</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>6-16-81</b>	
2. SEX <b>Female</b>		2b. HOUR <b>7:35 P.M.</b>	
3. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 30, 1891</b>	
4. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mercersburg, Pa.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS.	
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TOWSON MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N CHARLES ST</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Penna.</b>		13b. CITY OR TOWN <b>Franklin</b>	
13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13d. STREET ADDRESS <b>11 Linden Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Adam E. Steiger</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Orpha Myers</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>187-36-7828</b>	
17. INFORMANT <b>Lee S. Daub</b>		ADDRESS <b>2108 O St. N.W. Washington D.C. 20037</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF COLON</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>POST OP BOWEL OBSTRUCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 28</b> , 19 <b>81</b> , to <b>JUNE 16</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 16</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Michael B. Grecco</i>		22c. DATE SIGNED <b>6-16-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR MICHAEL GRECCO GRECCO</b>		22e. ADDRESS <b>GREATER BALTIMORE MEDICAL CENTER</b>	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>6/20/81</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fairview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mercersburg Franklin Pa.</b>	
24. FUNERAL DIRECTOR <i>F. W. Benninger</i>		25. REG. D. BY REGISTRAR <b>JUN 20 1981</b>	
ADDRESS <b>Mercersburg, Pa. 17236</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST <u>Virginia</u> MIDDLE <u>Dawson</u> LAST <u>Evelyn A FINN</u>					2a. DATE OF DEATH MONTH DAY YEAR <u>June 13, 1981</u>					2b. HOUR <u>2:45</u> M				
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Aug 22, 1906</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>74</u> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD							
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Franklin Square Hospital</u>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Clerk</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>				
13a. STATE <u>MD</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>8210 Diamond Pt. Rd</u>				
14. FATHER'S NAME FIRST MIDDLE LAST <u>Milton Dawson</u>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Enola Bullen</u>					16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u>				
16a. SOCIAL SECURITY NO. <u>218-10-0463A</u>					17. INFORMANT ADDRESS <u>Lawrence W. Russell, Jr 465 Walnut Dr. Edgewater, MD</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>1830</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> (c) <u>Ovarian carcinoma with abdominal carcinomatosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic heart disease - cardiovascular disease</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 21, 1981</u> to <u>June 13, 1981</u> , that (we) lost saw the deceased alive on <u>June 13, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <u>A. Pillemer</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
22c. DATE SIGNED <u>6/13/81</u>					22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ARTHUR PILLERMAN</u>					22e. ADDRESS <u>Franklin Square Hosp. Balt. Md</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 17, 1981</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Baltimore</u>			23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balt. MD</u>			25a. DATE REC'D. BY REGISTRAR <u>JUN 17 1981</u>				
24. FUNERAL DIRECTOR <u>Taylor F. H</u>					25b. REGISTRAR'S SIGNATURE <u>Chapman, md</u>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO.				8 1 1 4 5 4 9					
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Newland		E.		DAY				June 5 1981		9:15 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Male		White		Mar. 16 1918		63 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.Y.		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Ruxton		Manor Care N.H. Ruxton						Physician		Medical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Balto.		Ruxton				7903 Ruxway Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John H. Day		Jessie Newland									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
Yes		WW 11		386-18-6146		Janie D. Day		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Parkinson Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 12<sup>th</sup></u> 19 <u>79</u> to <u>June 5<sup>th</sup></u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>June 5<sup>th</sup></u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
<u>Kevin Quinn M.D.</u>								<u>6/6/81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Kevin Quinn M.D.		1205 York Rd., Lutherville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		6-8-81		Druid Ridge		Pikesville, Balto.		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henry W. Jenkins & Sons Co., Balto., Md.		1905 York Rd.				JUN 8 1981					

BP



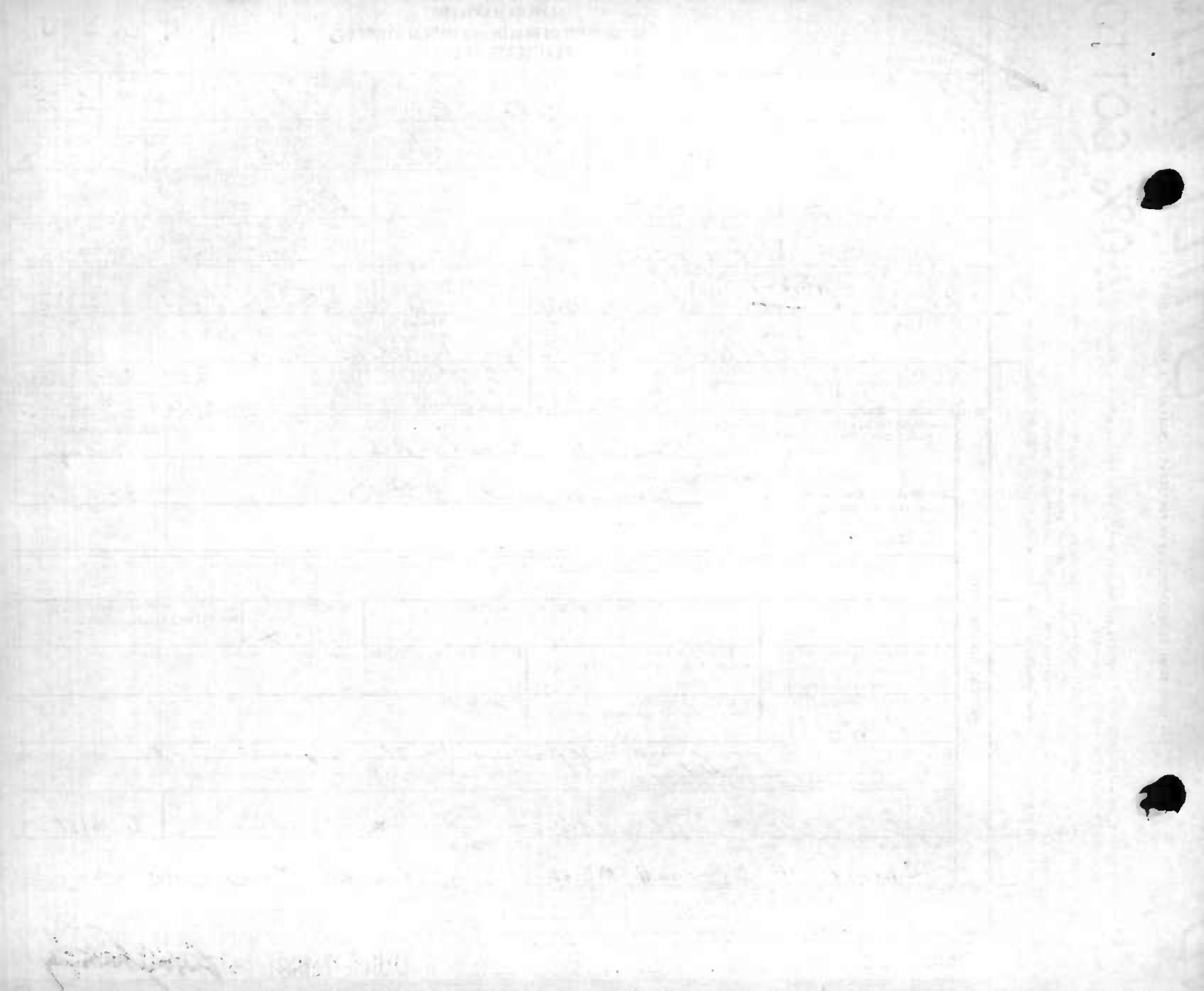
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 4 6 5 0  
CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Please reply by returning this certificate to the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[illegible]



TC MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR 415 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14651	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Herbert B. Dennis			2a. DATE KNOWN OF DEATH ESTI. MONTH DAY YEAR 6 15 1981			2b. HOUR 12:08 a.m.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 4, 1895		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 85		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 15 1981		7d. HOUR 12:08 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Rossville			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Boiler Engineer			12b. KIND OF BUSINESS OR INDUSTRY Armco Steel	
13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Middle River		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1428 Shore Road 21220		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur E. Dennis						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Corneila Fitzhugh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 216 05 7290			17. INFORMANT ADDRESS Rose D. Leavel 8 Geranium Place 21220					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <u>Electrocution</u> 9558 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Arteriosclerotic Cardiovascular Disease											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45 P.M. 6/14/81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was using an electrical to pump water out of his boat					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) rowboat near his home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1428 Shore Rd. Balto. Co., Md.					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 6-15-81		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.			ADDRESS 111 Penn Street								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6-18-81		23c. NAME OF CEMETERY OR CREMATORY Zion Lutheran Church Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland			
24. FUNERAL DIRECTOR Bronzinski Funeral Home						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Pistay K. Bundy		
1407 Old Eastern Ave.						JUN 18 1981					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		6/8/81		
Charles		A.		Desor				3:35 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Male		White		MONTH DAY YEAR		85 YRS.		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Missouri		U. S. A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville		Frederick Villa Nursing Center				Linotype oper.		newspaper		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		Baltimore		Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		213 Osborne Ave. 21228		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST					FIRST MIDDLE LAST					
Charles Jacob Desor					Emma Wherley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS			
No					212-01-6697		Raymond Desor, 10630 Breezewood Circle			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a):										
Bilateral Craniomeningitis										
4860										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
(b):										
DUE TO, OR AS A CONSEQUENCE OF										
(c):										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
			P.M. 19							
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION		CITY OR TOWN		COUNTY STATE
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET				
22a. I certify that (i) (this hospital) attended the deceased from 19 61 to 19 81, that (i) (we) last saw the deceased alive on 6/8/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.										
22b. SIGNATURE										
Herbert Lapp, M. D.										
22c. PHYSICIAN'S NAME (TYPE OR PRINT)										
Herbert Lapp, M. D.										
22d. ADDRESS										
4804 FREDERICK AVE 29										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN COUNTY STATE		
Burial		6/11/81		Loudon Park Cem.		Baltimore		Maryland		
24. FUNERAL DIRECTOR 1630 Edmondson Ave., Catonsville, Md.										
Witzke Funeral Home of Catonsville, P.A. 21228										
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE										
JUN 9 - 1981										

A . . .

16/8/0

10290

Charles

SLAP

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142025

2 3 4

Baltimore County

911v2m763

Frederick Villa Nursing Center

Maximal Bacterial Load

• 9V6 9m7c180 c15

544

Charles Jacob Deane

Why?

212-01-0097 Raymond Deor, 10030 Brezewood Circle

Q4

Robert L. D.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

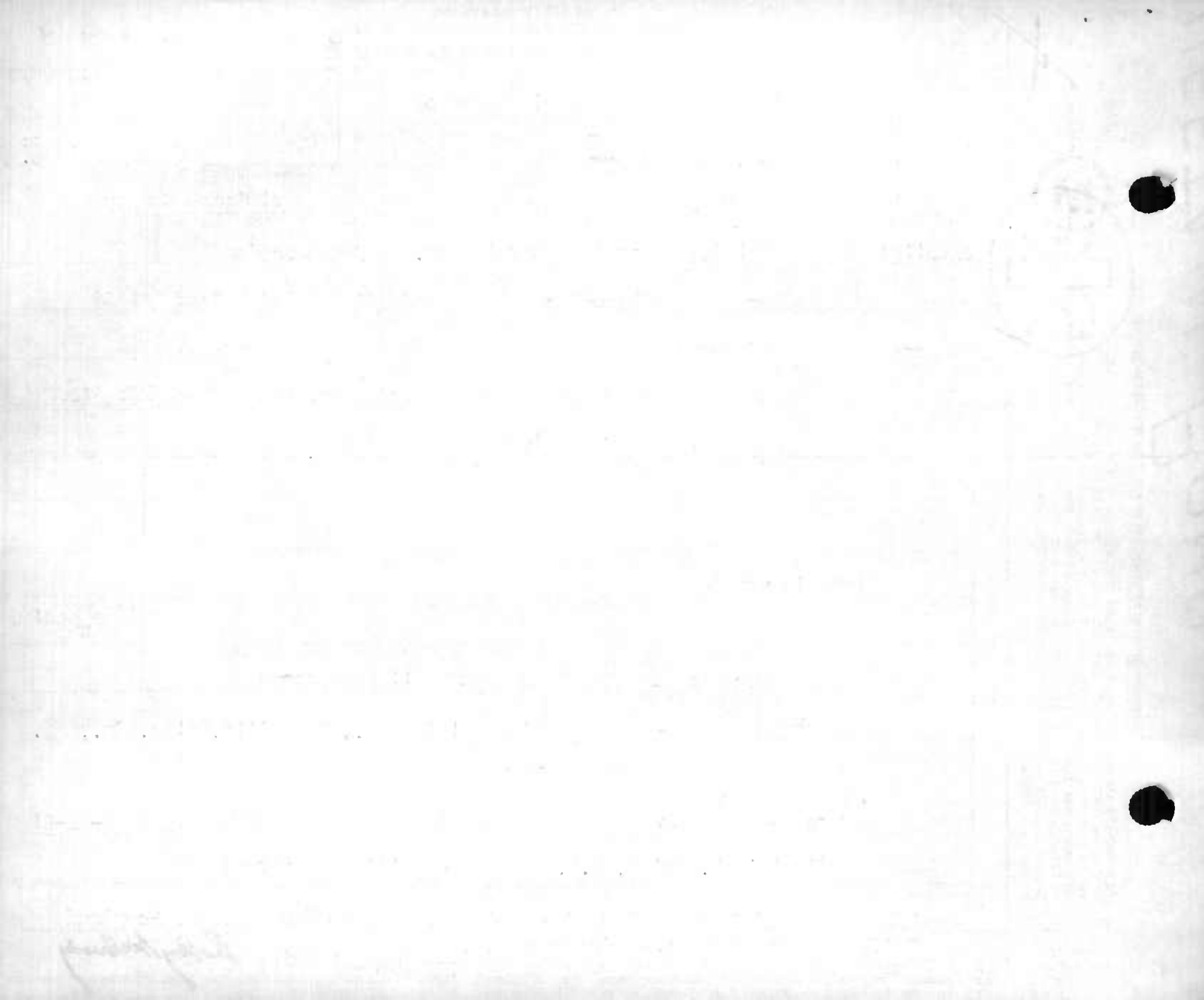
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Pasquale						DiCrescenzo		XX		6		22		19 81		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	March 20, 1894		27 YRS.						6		22		19 81		5:30 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Italy		U.S.A.				Baltimore County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Randallstown		Baltimore County General Hosp.		Construction-													
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Pikesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4120 Raleigh Road		21208							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Vincent		Di Crescenzo		Maria		Unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Mrs. Mary Berman											
No		215-05-1165		4120 Raleigh Rd.		Pikesville, MD.		21208									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
8809						DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.						(b)											
						DUE TO, OR AS A CONSEQUENCE OF											
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.		Blunt injury to head															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? (head only)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		3:00XX 6 22 1981		subject fell down steps													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		home		4120 Raleigh Rd., Pikesville, Balto. Co., Md.													
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from:		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Virginia L. Dolan		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		6-22-81							
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		6/25/81		Lorraine Park Cem.		Woodlawn Balto. Maryland											
24. FUNERAL DIRECTOR NAME		Loring Byers Funeral Directors, P.A.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
8728 Liberty Road Randallstown, Maryland		21133		JUN 23 1981		Loring Byers											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR 12 HOURS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva B. Dierkes						2a. DATE OF DEATH MONTH DAY YEAR 6 8 81		2b. HOUR P M 6:10 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 19 91		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Villa Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) seamstress		12b. KIND OF BUSINESS OR INDUSTRY garment			
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5605 Oregon Avenue, 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Michael Friedman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Margaret Wetschurak				16. ADDRESS Wettschuleck			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-28-5313		17. INFORMANT ADDRESS Margie Monell 1113 Plover Drive							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Congestive heart failure, (coronary)</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Colin &amp; R. hem. collecting</i> (c) <i>Definitive squamous cell ca</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF primary site unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wondwosen Abdi				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/9/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wondwosen Abdi				22e. ADDRESS 5411 Old Frederick Rd.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 06-12-81		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR JUN 10 1981		25b. REGISTRAR'S SIGNATURE <i>Robert M. ...</i>			

5411 Old Frederick Rd.

ibid. no. 20, 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 5 5	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
Jack DILEONARDI DiLeonardi, SR.				June 6, 1981 1:25A <sub>M</sub>	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male	White	Oct. 8, 1930		50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland	U.S.A.			Baltimore County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rossville		Franklin Square Hospital		Hair Stylist	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Baltimore	Essex	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5527 Lanham Way
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Anthony DiLeonardi			Grace Montalbo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		212-26-8122		Frances M. DiLeonardi Same as # 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>					
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio-vascular disease</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 6, 1981, to June 6, 1981, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 6, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (We) did not view the body after death.					
22b. SIGNATURE				22c. DATE SIGNED	
Henry Sacerio, M.D.				6/6/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Henry Sacerio, M.D.				9000 Franklin Square Dr., 21237	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		June 9, 1981		Greenmount	
23d. LOCATION		23e. STATE			
Baltimore, Maryland					
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR	
Leonard J. Ruck, Inc.				JUN 8 1981	
25b. REGISTRAR'S SIGNATURE					
Baltimore, Md.					

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1981 8 JUL

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

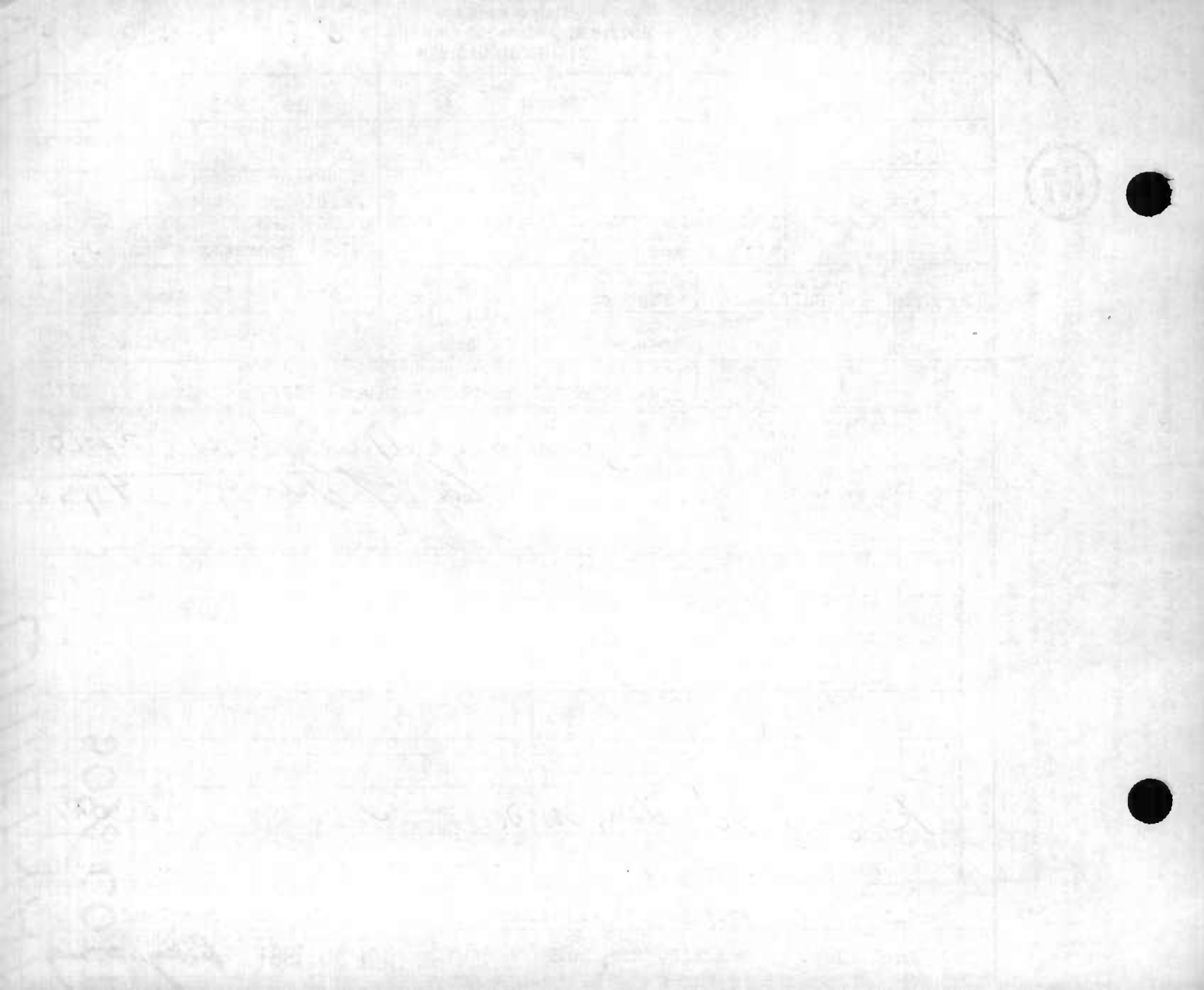
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Murel O Diven</b>			June 19, 1981			M		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 8, 1913</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Edgemere</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9119 B Ave</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Block Operator</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Penn R.R.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Edgemere</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>9119 B Ave</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hugh E Diven</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Faber</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-05-5592</b>	17. INFORMANT <b>Mr Thomas Diven</b>			ADDRESS <b>9124 C Ave 21219</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Rubefaction</b> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>a of lung</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos 4 yrs.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Roger G Windsor, M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>6/20/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Roger G Windsor M.D.</b>				22e. ADDRESS <b>2802 North Point Rd Baltimore, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck Inc. Dundalk, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. McBrady</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 5 7	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR a	
Helen Dorothy DJUBEK						June 19, 1981				12:52 M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		5 MONTH 30 YEAR 1922		59 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville		Franklin Square Hospital				Tele. Operator		C. & P. Phone Co.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Baltimore		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1917 Midland Road			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST				FIRST MIDDLE LAST							
Richard F. Saunders				Mary Margaret Staab							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				217-18-6319		Steve J. Djubek		1917 Midland Rd. Balto., MD. 21222			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>Peritonitis Secondary to Ruptured Diverticulum</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <u>Ovarian Carcinoma</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 14</u> , 19 <u>81</u> , to <u>June 19</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>June 19</u> , 19 <u>81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
<input checked="" type="checkbox"/> William A. Bode				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				6-19-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
William A. Bode M.D.				9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				6/22/1981		Holly Hill		White Marsh Maryland			
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Duda-Ruck, Inc.				7922 Wise Avenue Dundalk, MD. 21222				JUN 23 1981		<i>Robert M. Brady</i>	

BP



X

X [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EDWARD C DORAK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 26, 1981</b>	
3. SEX <b>MALE</b>		2b. HOUR <b>1:30a</b>	
4. RACE <b>WHITE</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>	
5. DATE OF BIRTH <b>OCT. 7, 1915</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>SAINT JOSEPH HOSPITAL</b>	
12a. USUAL OCCUPATION (TYPE OR MOST OF WORKING LIFE) <b>SECURITY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GENERAL MOTORS</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>	
13c. CITY OR TOWN <b>PARKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>3123 HESS AVENUE</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANDREW DORAK SR.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY KOSCIOLEK</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>100 10 8536</b>	
17. INFORMANT ADDRESS <b>JOSEPHINE DORAK 3123 HESS AVE. BALTO. MD. 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4300 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF <b>(b) ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) ASPIRATION PNEUMONIA</b> IMMEDIATE CAUSE (b) IMMEDIATE CAUSE (c) <b>10 DAYS 10 DAYS</b>			
PART II. MULTIPLE DECUBITUS ULCER; S/R SUBARACHNOID BLEED <b>MULTIPLE DECUBITUS ULCER; S/R SUBARACHNOID BLEED</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6-12 19 81</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>6-26 19 81</b>		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from <b>6-12 19 81</b> to <b>6-26 19 81</b> that (we) last saw the deceased alive on <b>6-26 19 81</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)			
22b. SIGNATURE <b>Jorge C. Secada-Lovio, MD</b>		22c. DATE SIGNED <b>6-26-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.C. SECADA-LOVIO, MD</b>		22e. ADDRESS <b>7620 YORK RD BALTIMORE, MD. 21204</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/29/1981</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MORELAND MEMORIAL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>DIPPEL FUNERAL HOMES 7110 BELAIR RD. BALTO. MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP





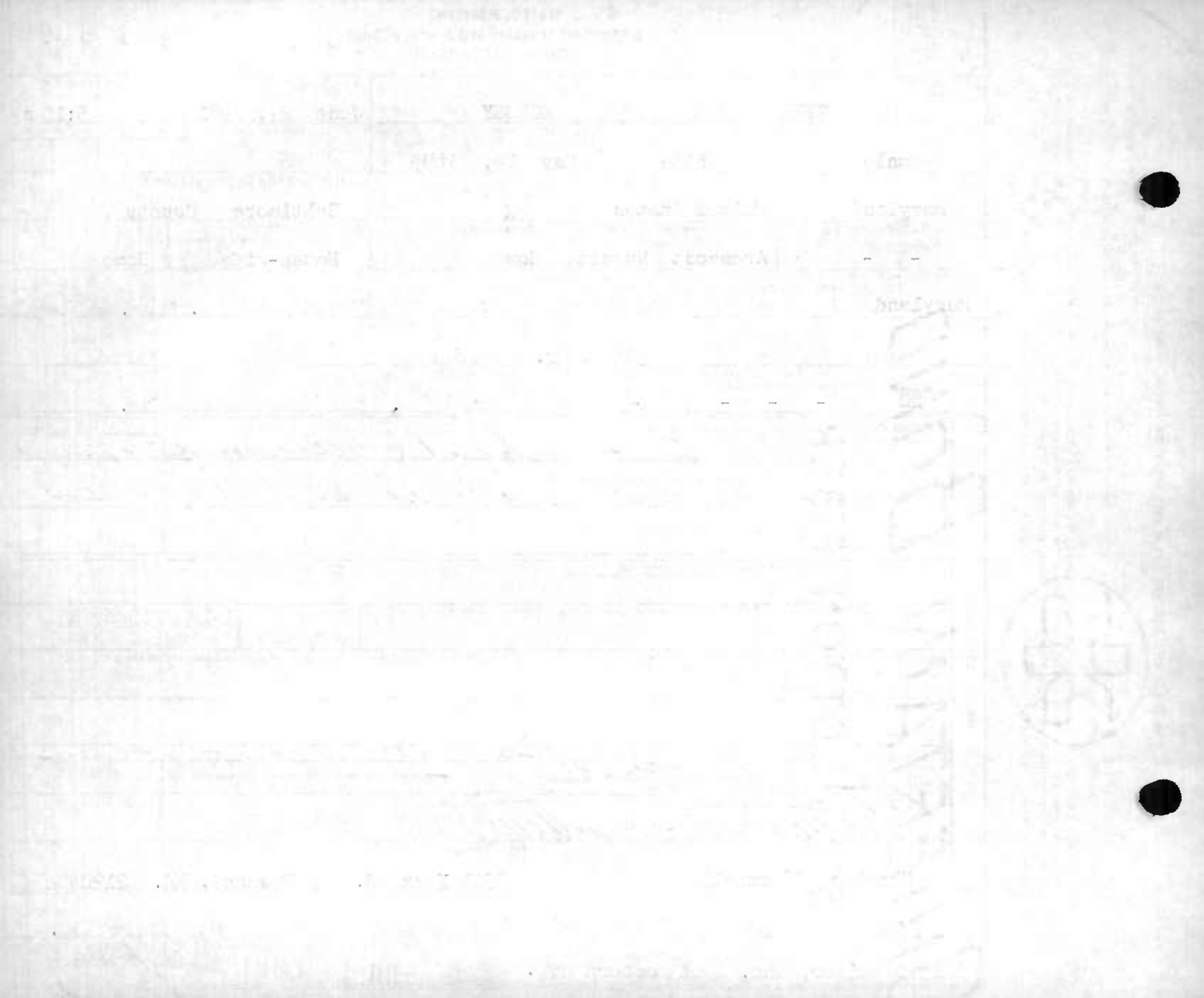
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 5 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL Gale DORSEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 27, 1981</b>			2b. HOUR <b>5:10 a.m.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 19, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>- -</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Armecost Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House-wife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>Homewood Apts. Chas. &amp; 31st St</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John - Gale, Jr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emiley Raisin Germill</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-74-6868</b>	
17. INFORMANT ADDRESS <b>Dorothy D. Bair 1106 Malvern Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized ASCVD</b> 595 DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/20</b> 19 <b>81</b> , to <b>6/27</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Charles O'Donnell</b>				22c. DATE SIGNED		22d. DATE SIGNED	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles O'Donnell</b>				22f. ADDRESS <b>7501 York Rd. / Towson, Md. 21204</b>		22g. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 30 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Lilly &amp; Zeiler, Inc. 1901 Eastern Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 1 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Brady</b>	

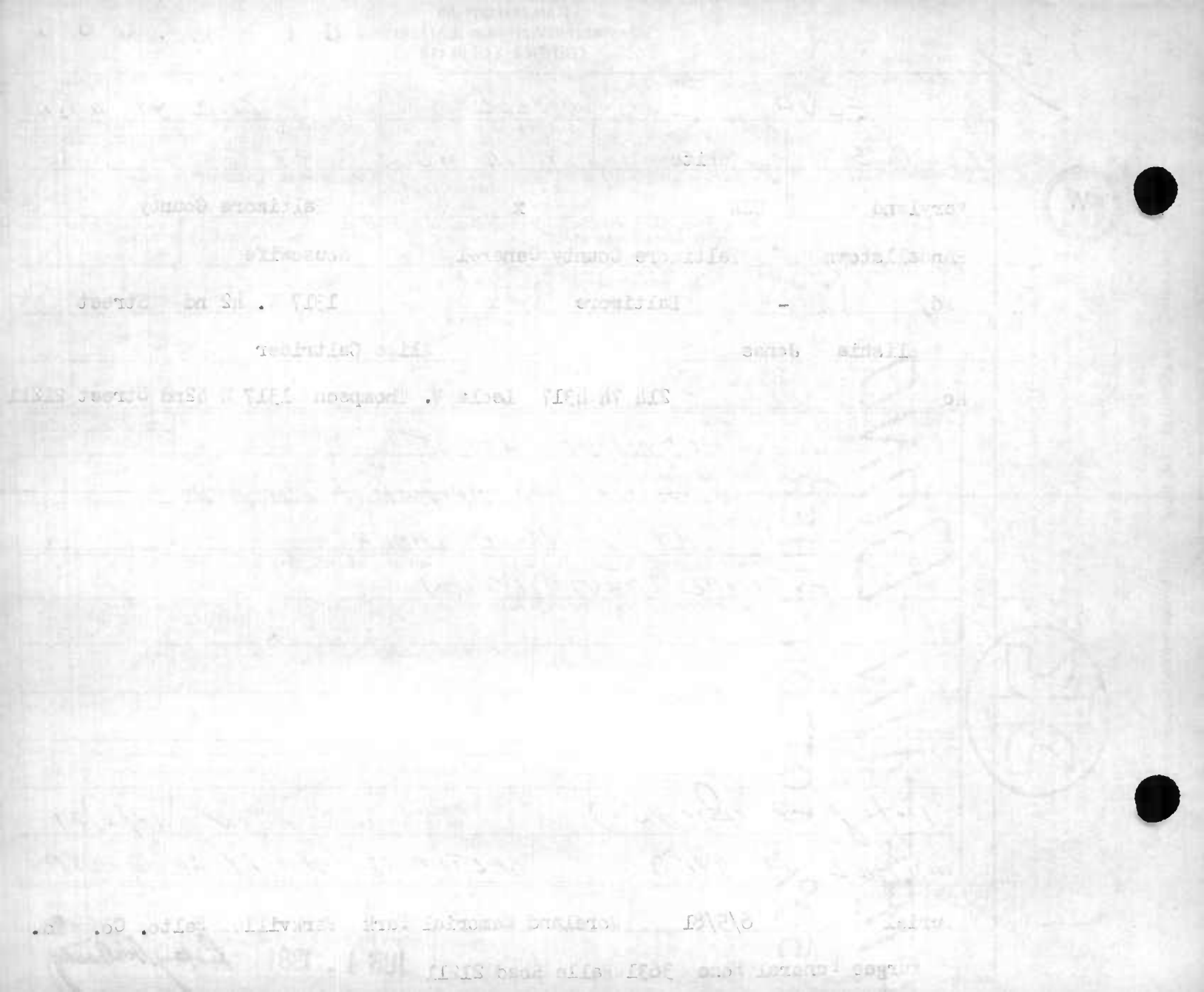


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8114660			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 6 2 81			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELVA L. DOVELL				2b. HOUR 4:12 AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 14 94		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md				13b. STREET ADDRESS 1317 W. 42 nd Street		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Elishia Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Caltrider			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 214 74 4317		17. INFORMANT ADDRESS Leola V. Thompson 1317 W 42nd Street 21211	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPOTENSIVE SHOCK</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>INTESTINAL OBSTRUCTION</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE OF PHYSICIAN (TYPE OR PRINT) HAFEED A SYED				DEGREE		22c. DATE SIGNED 6/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFEED A SYED				22e. ADDRESS BALTIMORE COUNTY GEN HOSP		22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/5/81		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Balto. Co. Md.	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home				ADDRESS 3631 Falle Road 21211		25a. DATE REC'D. BY REGISTRAR JUN 4 - 1981	
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 1 1 4 6 6 1 CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Francis F. Downey					June 1, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR A.M.	
Male		White		Oct. 15, 1902		78		6 M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Boston, Mass.		U.S.A.				Baltimore County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF PREVIOUS YEAR)		12b. KIND OF BUSINESS OR INDUSTRY	
Catonsville		319 Harlem Lane				Engineer		U.S. Govt.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md.		Baltimore		Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		319 Harlem Lane	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Francis P. Downey					Isabelle T. Frackelton				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
No					010-10-93624		Catonsville, Md. 21228. David C. Downey - 319 Harlem Lane		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 4140 ASHD - Cardiac Arrest									
DUE TO, OR AS A CONSEQUENCE OF (b) years									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD - severe									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from January 19 81, to June 19 81, that (I) (we) last saw the deceased alive on 5/20 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
James Mellow MD					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6/4/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
NOLAN					1 Mellow Ave Baltimore 21229				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		6/4/81		Lake View Mem. Park-		Sykesville, Maryland			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Sterling Funeral Estate 736 Edmondson Ave. Catonsville, Md. 21228				JUN 3 1981		[Signature]			

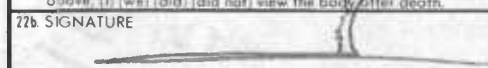
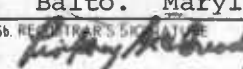
17

NOT 103.6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 6 2			
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Joseph Vincent Doyle					2a. DATE OF DEATH MONTH DAY YEAR 6 - 16 - 81					2b. HOUR 10 1/2 P.M.			
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 7 - 28 - 04		6. AGE (IN YEARS (LAST BIRTHDAY)) 76 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Co. MD.							
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Stella Maris Hospice				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk			12b. KIND OF BUSINESS OR INDUSTRY steel mill				
13a. STATE Md.					13b. COUNTY BALTO.		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2918 Cornwall Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Doyle					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McNamara								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-3MAS-213-09-002-A		17. INFORMANT STella Maris Hospice					ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/16/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Eddie Harkbuda						22e. ADDRESS Stella Maris Hospice							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/19/1981		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus			23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk Balto. Maryland					
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Dundalk Md 21222						25a. DATE REC'D. BY REGISTRAR JUN 19 1981		25b. REGISTRAR'S SIGNATURE 					





STANDARD

1051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 6 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>HARRY DRESSER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-3-81</b>		2b. HOUR <b>12 45 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 11, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>POSTAL CLERK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>BALTIMORE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>3501 BEAGLE LA., APT. 202</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM DRESSIN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWII-ARMY 064-03-8129A</b>		17. INFORMANT <b>MRS. BETTE G. DRESSER</b> ADDRESS <b>3501 BEAGLE LA., APT. 202 RANDALLSTOWN, MD 21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of the liver and Hepatic failure</b> 5715 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4-19-81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-19-81</b> to <b>6-3-81</b> , that (I) (we) last saw the deceased alive on <b>6-3-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Soon Chul Hong</b>		DEGREE		22c. DATE SIGNED <b>6-3-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOON CHUL HONG</b>		22e. ADDRESS <b>Baltimore County General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/5/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SHAAREI TFILOH</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		23e. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>		ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

21-15-78

DREWER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 6 6 4			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
NADA		s.		DRIGAN				6		14	81	2:30	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		August 4, 1924		56		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		U.S.A.				Baltimore County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Towson		Greater Baltimore Medical Center		Homemaker									
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
Maryland		Baltimore		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		40 Atherton Road					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Michael		Shoop		Sarah		Alfrata		Rodey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		211-18-1220		Mr. Daniel Drigan		40 Atherton Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:										20 MIN			
IMMEDIATE CAUSE (a) <b>CARIORESPIRATORY ARREST</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA OF THE BREAST</b>										4 YRS			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET									
22a. I certify that (I) (this hospital) attended the deceased from <b>6-11</b> , 19 <b>81</b> , to <b>6-14</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6-14</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<i>Michael B. Grieco</i>						6-14-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
MICHAEL GRIECO		GBMC-6701 NORTH CHARLES ST.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		6-16-1981		Dulaney Valley		Cockeysville						Maryland	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ruck Towson Funeral Home, Inc.		Towson, Maryland		1050 York Road		JUN 15 1981		<i>Anthony Anthony</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR					1 DECEASED NAME FIRST MIDDLE LAST <b>RACHEL Ellis DUNLAP</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6/20/81</b>		2b. HOUR <b>3:50AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-16-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.							
10. CITY OR TOWN OF DEATH <b>TOWSON, MD.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC-6701 N. CHARLES ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balto City</b>					
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6821 Blenheim Rd 21212</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James G. Ellis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Addie Ellis McWilliams</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-40-5124</b>		17. INFORMANT ADDRESS <b>Mrs Robert Wevodau 69 Fried Dr 17018</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>3483</b> IMMEDIATE CAUSE (a) <b>Confluent broncho pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metabolic encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <b>R. Greiteneker</b>				DEGREE				22c. DATE SIGNED <b>6/20/81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. GREITENECKER</b>				22e. ADDRESS <b>GBMC 6701 N. Chas. St 21204</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-24-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Galestown Meth Ch Cem</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Galestown Dorchester Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b>				ADDRESS <b>6500 Kork Rd 21212</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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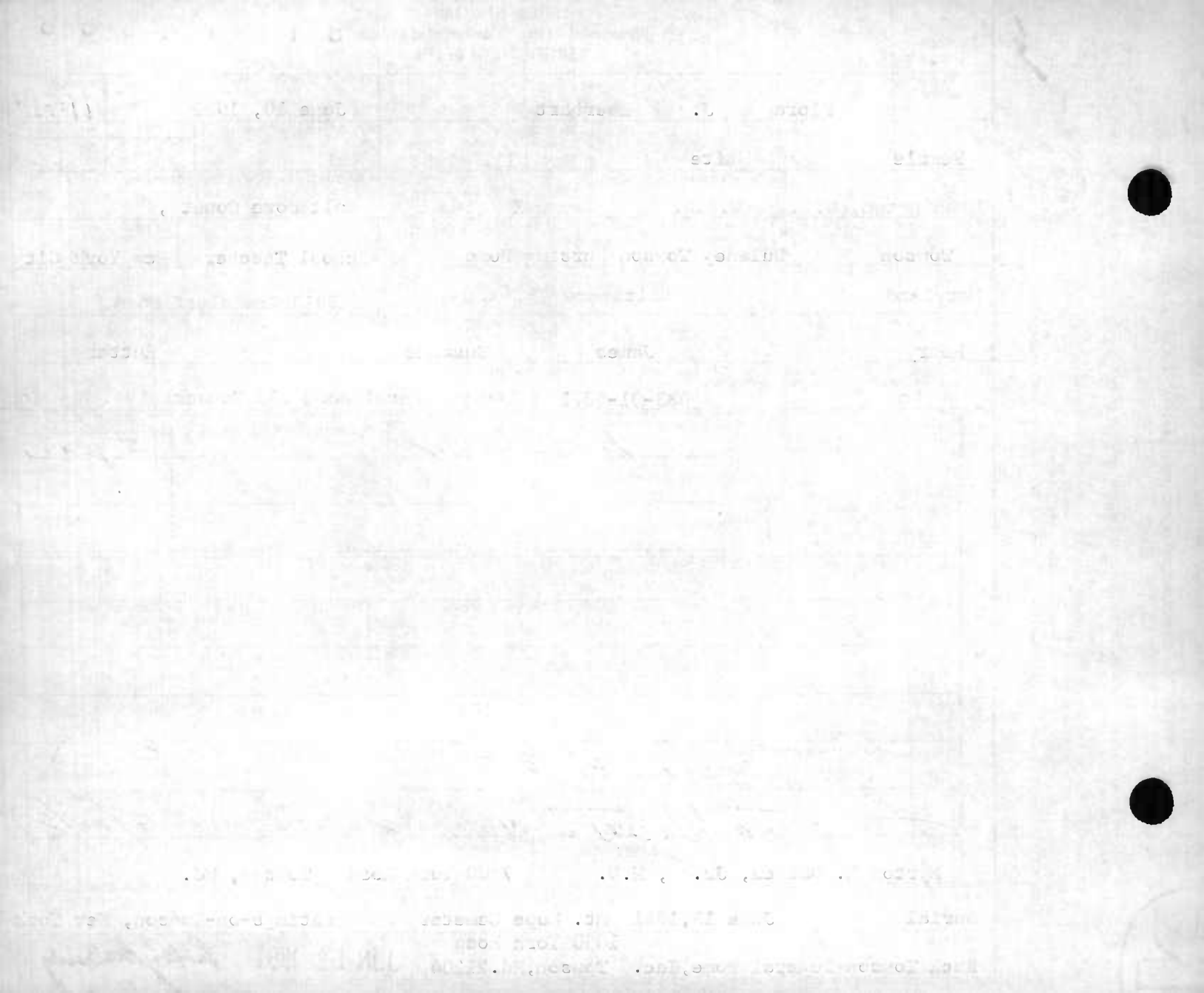


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Flora J. Eberhart					June 10, 1981				
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Female		White		May 11, 1898		83 YRS.		11:05 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D.C.		U.S.A.				Baltimore County, MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Dulaney Towson Nursing Home				School Teacher		New York City	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5013 Greenleaf Road	
14 FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Henry James					Suzanne Rutter				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS					
No		083-01-6871		Havey Funeral Home 732 Yonkers Ave. New York					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HASCV</u>									
4029 DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1981</u> to <u>May 7, 1981</u> , that (I) (we) last saw the deceased alive on <u>May 7, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Myrton L. Gaines, Jr.</u>		MD						6/10/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Myrton L. Gaines, Jr., M.D.		7800 York Road Towson, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		June 13, 1981		Mt. Hope Cemetery		Hastings-on-Hudson, New York			
24 FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ruck Towson Funeral Home, Inc.		Towson, Md. 21204		JUN 12 1981		<u>John H. H. H.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 1 4 6 6 7			
1. DECEASED NAME (TYPE OR PRINT) <b>JAMES H EVERETT</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 14, 1981</b>				2b. HOUR <b>2:15 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 14, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Balt. City Fire Dept.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>Balt., Md. 21206 4116 White Avenue</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Everett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Not Known</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-46-0014</b>		17. INFORMANT <b>Daughter: Martha M. Everett</b>		ADDRESS <b>Balt., Md. 21206 4116 White Avenue</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100 MYOCARDIAL INFARCTION</b> IMMEDIATE CAUSE (a) <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PROSTATIC CARCINOMA</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>June 6, 1981</b> to <b>June 14, 1981</b> , that (I) (we) last saw the deceased alive on <b>June 14th 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>RUPAK C. MITRA, MD</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>06-14-81</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUPAK C. MITRA, MD</b>		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jun 18 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Most Holy Redeemer</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>		25b. REGISTRAR'S SIGNATURE <i>R. J. Ruck</i>					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M/2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
David Joseph Evry								6 8 1981								M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male		White		Sept. 10, 39		41 YRS.				6 8 1981						4:40 P M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										MD	
Maryland		U.S.A.				Baltimore County											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Randallstown		Baltimore County General Hospital		Salesman-Kitchen Distrib.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Baltimore		Larchmont		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2635 West Park Drive									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Louis Evry		Sandra Rosenfeld															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Mrs. Margaret F. Evry											
No		212-36-6018		2635 West Park Dr.		21207											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4292		IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)		DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		Margarita A. Korell, M.D.		TITLE (SPECIFY)		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		6/9/81					
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE					
Burial		6/11/81		Woodlawn Cemetery		Woodlawn		Balto.		MD.							
24. FUNERAL DIRECTOR NAME		Loring Byers Funeral Directors, P.A.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
8728 Liberty Road		Randallstown, MD. 21133		JUN 12 1981													



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLES R. EYLER</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 28 19 81</b>			2b. HOUR M <b>7:15</b> P <b>8</b>		
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/3/28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 28 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH <b>ESSEX</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>813 Arncliffe Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OP. ENGINEER</b>			
13a. STATE <b>MD.</b>				13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>813 ARNCLIFFE RD.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES E. EYLER</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GLENNA FRESHMAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT ADDRESS <b>MARTHA EYLER ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9552</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of head (rifle)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>XXX</b> MONTH DAY YEAR <b>? P.M. 6-28-1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted.</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>813 Arncliffe Rd. Balto. Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>6-29-81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. G. CONNELLY 300 MACE</b>						25a. DATE REC'D. BY REGISTRAR <b>JUL 1 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



MEET WITH BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 7 0	
1 - FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Vallie C. Fahey</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 17, 1981</b>		2b. HOUR A. M. <b>9</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH (1887) MONTH DAY YEAR <b>10 - 23 - 87</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>			9b. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>		
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5214 Cromarty Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>5214 Cromarty Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>B. Benjamin Minghini</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Woods</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-44-4114</b>		17. INFORMANT <b>Baltimore, Md. 21229.</b> <b>Miss Dorothy L. Fahey-5214 Cromarty Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema - L. H. F.</b> 2765 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary Edema - dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Jorge H. Ordonez-Smith, MD</b>		DEGREE <b>MD.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jorge H. Ordonez-Smith, MD</b>		22e. ADDRESS <b>303 N. Rolling Rd. Baltimore, Md. 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery - Baltimore, Md.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Stirling Funeral Estate</b> <b>736 Edmondson Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>			
25b. REGISTRAR'S SIGNATURE <b>Catonsville, Md. 21228</b>					

(1951)

72-55-704

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

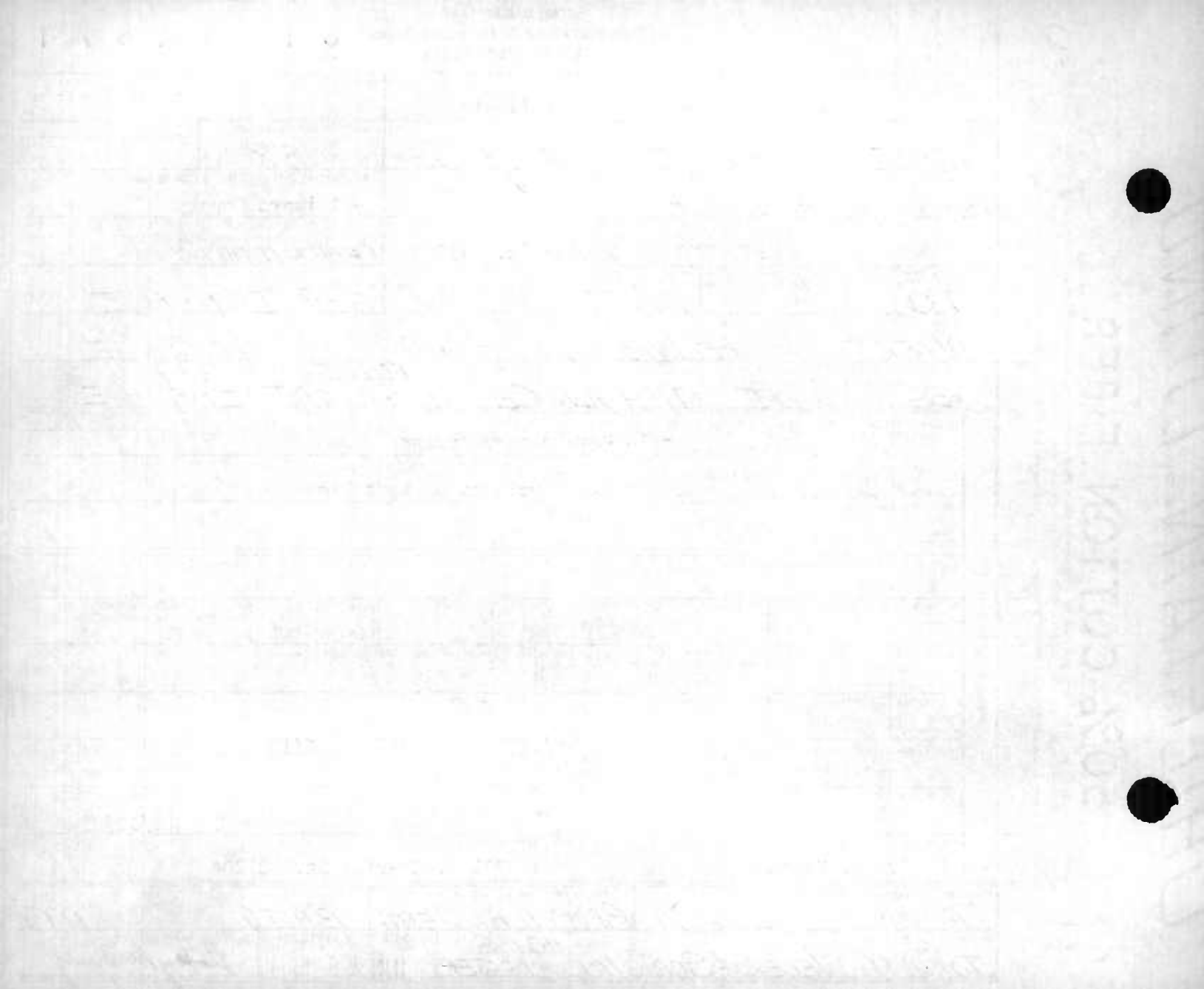
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 6 7 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>George A. Fellmeth</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 12 81</b>		2b. HOUR <b>12:50P</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 13 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles St. 21204</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DRAFTSMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE <b>MD</b>	13b. COUNTY <b>BALTO</b>	13c. CITY OR TOWN <b>BALTO</b>	13e. STREET ADDRESS <b>339 TDA AVE</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT FELLMETH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARA MCGUIRE</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>177-14-1610</b>		17. INFORMANT <b>CECILIA SEUGAT</b> ADDRESS <b>339 TDA AVE.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <b>1890 Cardio Respiratory Arrest</b>							
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Carcinoma of Left Kidney</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/11</b> , 19 <b>81</b> , to <b>6/12</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/11</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Apparao N. Vanguri</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/12/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. A. Vanguri</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-16-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO NAT CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR NAME <b>JOHN M. WEBER &amp; SONS INC</b> ADDRESS <b>401 S CHESTER</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 16 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrady</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 7 2			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				3b. HOUR			
FIRST MIDDLE LAST <b>Albert Anthony FIORINO</b>				MONTH DAY YEAR <b>June 21, 1981</b>				a <b>12:20 M</b>			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White		MONTH DAY YEAR <b>4 27 1930</b>		51 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville		Franklin Square Hospital				Laborer		Balto. County			
13a. STATE				13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7547 Ives Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST <b>John Fiorino</b>				FIRST MIDDLE LAST <b>Mary Cimino</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				217-26-3682		7547 Ives Lane Charlotte J. Fiorino-Balto. MD. 21222					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Secondary to Oat Cell Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (this hospital) attended the deceased from <b>June 19</b> , 19 <b>81</b> , to <b>June 21</b> , 19 <b>81</b> , that (we) lost saw the deceased alive on <b>June 21</b> , 19 <b>81</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) not view the body after death.											
22b. SIGNATURE <b>P.A. Baltatzis</b>						DEGREE <b>MD.</b>		22c. DATE SIGNED <b>6-21-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Panayiotis A. Baltatzis M.D.</b>						22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/24/1981		Most Holy Redeemer		Baltimore Maryland					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc.</b> <b>7922 Wise Avenue Dundalk, MD. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Henry Hebrun</i>			

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18-15-3-1

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18-15-3-1

18-15-3-1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

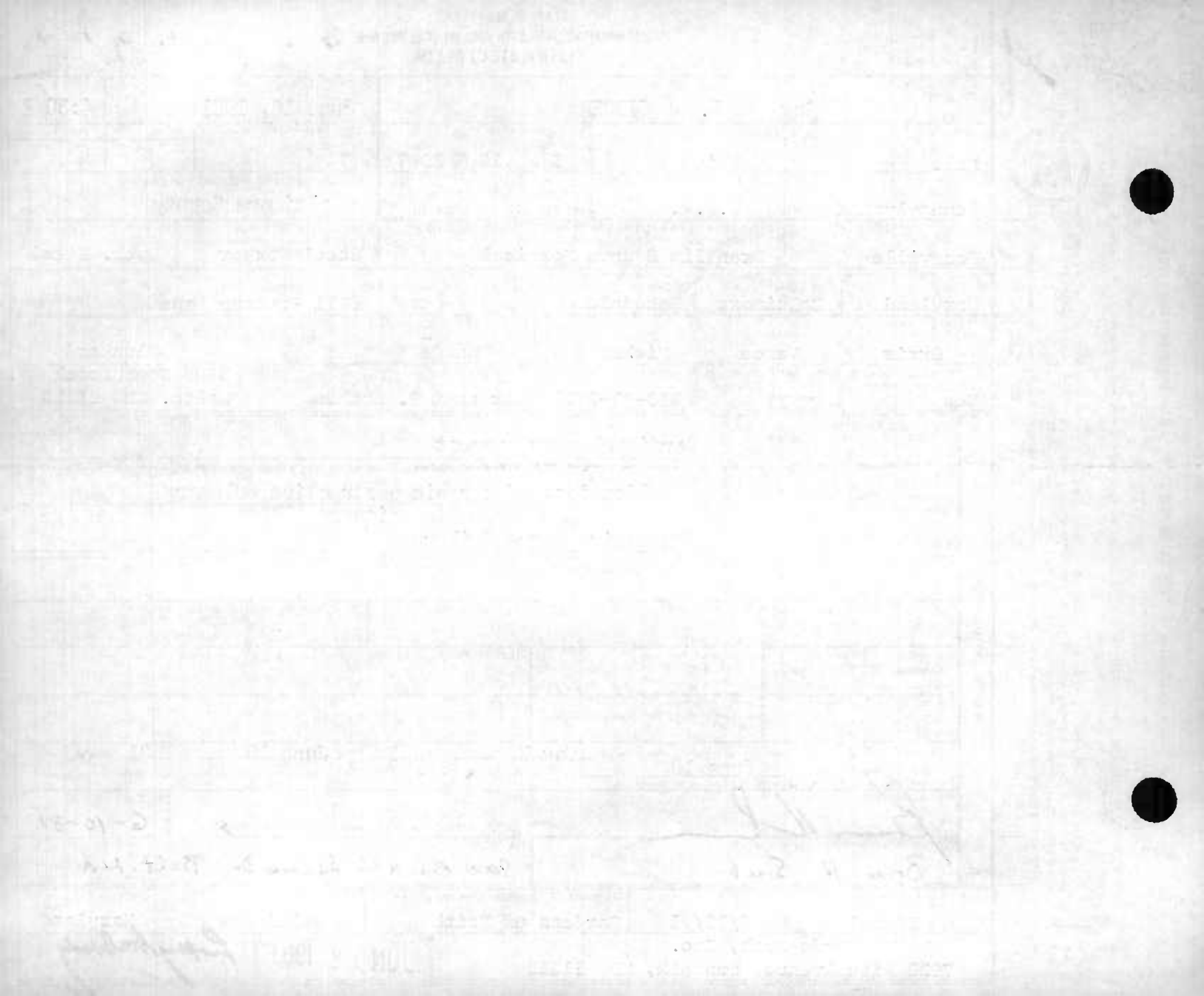
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Guy E. FISHER			2a. DATE OF DEATH MONTH DAY YEAR June 10, 1981		2b. HOUR 4:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 18 1907		
6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		10. CITY OR TOWN OF DEATH Rossville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Square Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steel Worker		12b. KIND OF BUSINESS OR INDUSTRY Beth. Steel				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Rosedale		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8711 Fontana Lane				
14. FATHER'S NAME FIRST MIDDLE LAST Orris Vance Fisher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Plunkard				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 213-07-3931		17. INFORMANT Margaret F. Sothen		
				ADDRESS 2805 Southbrook Rd. Balto. MD 21222		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4280 } DUE TO, OR AS A CONSEQUENCE OF (b) Complications of chronic obstructive pulmonary disease (c) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22. I certify that (this hospital) attended the deceased from May 7, 19 81, to June 10, 19 81, that (we) lost saw the deceased alive on June 10, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I we) (did) (did not) view the body after death.						
22a. SIGNATURE B. R. Sims		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6-10-81		
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Brian R. Sims		22d. ADDRESS 9000 Franklin Square Dr. Balt. Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/13/81		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland						
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc.		ADDRESS 7922 Wise Avenue, Dundalk, MD 21222		25a. DATE REC'D. BY REGISTRAR JUN 12 1981		



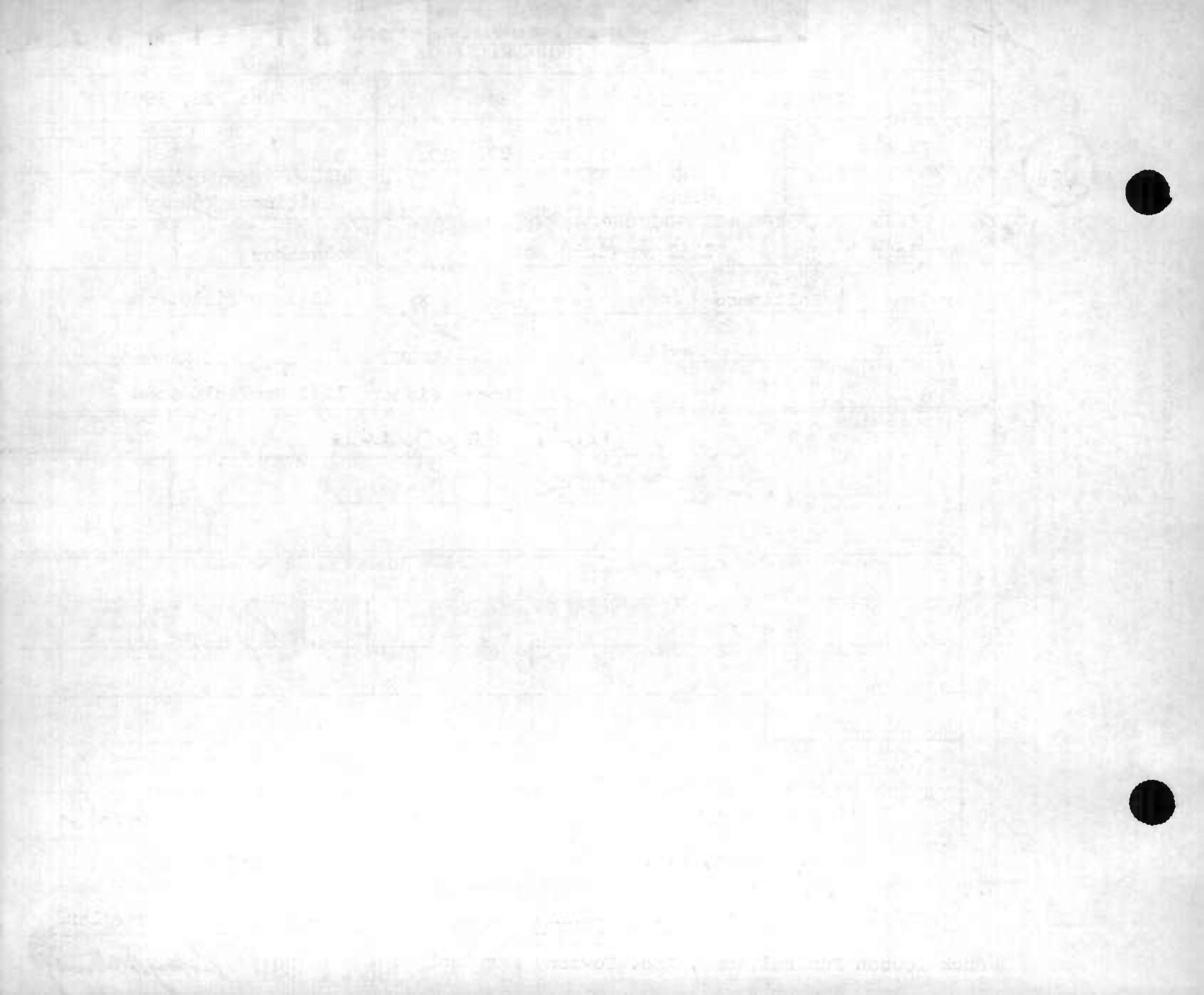
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8114674	
FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARGARET CECELIA FISHER</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1981</b>			2b. HOUR M		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 29, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Woodlawn</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1242 Newfield Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1242 Newfield Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Stephen Haviland</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Kennedy</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-28-0444</b>		17. INFORMANT ADDRESS <b>Thomas Fisher 1242 Newfield Road</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute coronary</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>asym</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Elmo M. Gayoso</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/23/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Elmo M. Gayoso, M.D.</b>					22e. ADDRESS <b>5411 Old Frederick Road</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-25-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>					ADDRESS <b>Towson, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 24 1981</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. McBrady</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	6	7	5	
1 - FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EARL WILLIAM FITCH</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>June 11, 1981</b>				2b. HOUR <b>8:05p M</b>			
3. SEX <b>Male</b>			4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-15-1912</b> YEAR			6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U/S/ A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>									
10. CITY OR TOWN OF DEATH <b>Rossville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck - driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self-Employ.</b>								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>										13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Perry Hall</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3869B Schroeder Ave. 21128</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry W. Fitch</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Deborah McClain</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>218-09-7365</b>			17. INFORMANT <b>Perry Hall, Md. 21128</b> <b>Mr. James E. Fitch, 3869C Schroeder Ave.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>RENAL FAILURE</b> (c) <b>DIABETES MELLITUS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF YES, NOTIFY MEDICAL EXAMINER) <b>NO</b>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>---</b>												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>NONE</b>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>												
22a. I certify that (a) (this hospital) attended the deceased from <b>JUNE 5, 1981</b> to <b>JUNE 11, 1981</b> , that (b) (we) lost above, (c) (did) (did not) view the body after death, and that in (d) (our) opinion death occurred on the date and hour and from the causes stated.																	
22b. SIGNATURE <b>Charles F. Hoesch, M.D.</b>								DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6-12-81</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES F. HOESCH, M.D.</b>								22e. ADDRESS <b>9712 BELAIR RD. APT 21236</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6-15-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial Gar.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Belair Harford Md.</b>									
24. FUNERAL DIRECTOR NAME ADDRESS <b>E.F. Bassah, 11750 Belair Rd. Kingsville, Md. 21087</b>								25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McClain</b>							

BP



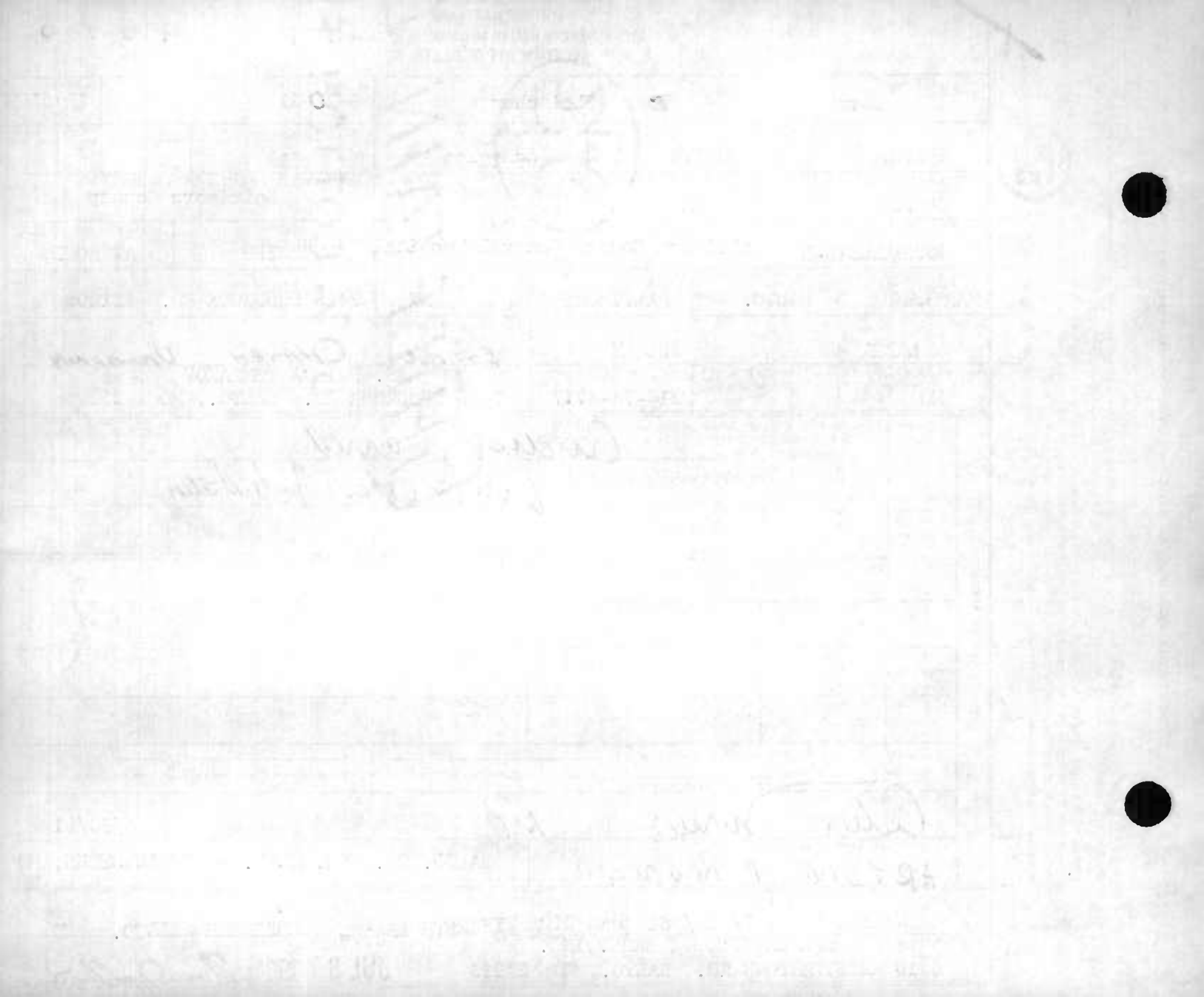
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dora</b> <b>Fleischer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-30-81</b>		2b. HOUR <b>11:50PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09-22-99</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Baltimore County General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>LAZER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER CHANAN UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-74-4717</b>		17. INFORMANT <b>MRS. FRIEDA TOMPAKOV</b> <b>7415 SUDBROOK RD. BALTO., MD 21208</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4274</b> IMMEDIATE CAUSE (a) <b>Cancer, aortic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>unfunctional Intubation</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/30/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTURO P. NOMEZ</b>		22e. ADDRESS <b>BALTO. CO. GEN. HOSP. - RANDALLSTOWN, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>7/ 2 / 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO MD</b>
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JUL 8 1981</b> <b>[Signature]</b>		





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 6 7 7

REG. NO.

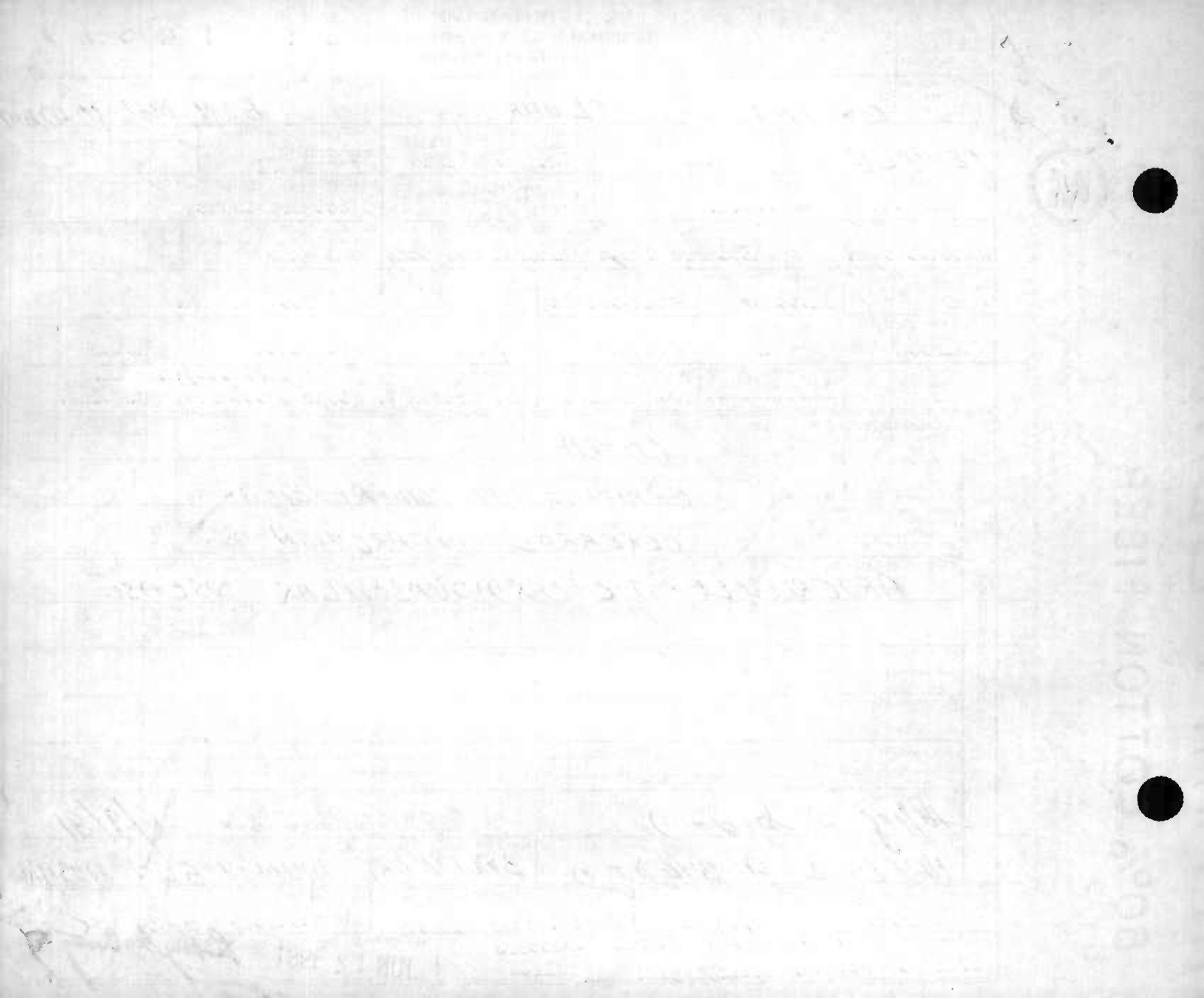
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY FLOHR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 9 1981</b>			2b. HOUR <b>10:42 AM</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 7 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE <b>MD</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Randallstown</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harold K. Seymour</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Adda Virginia Fuller</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>3636 Clifmar Rd.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>800-02-8102</b>			17. INFORMANT <b>Mr. Arnold V. Flohr Baltimore, Md. 21207</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COMA</b> <b>4349</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>BRAIN STEM COMPRESSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CEREBRAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Hafeez A Syed M.D.</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/9/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAFAEEZ A SYED M.D.</b>						22e. ADDRESS <b>BALTIMORE COUNTY GEN HOSPITAL</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/12/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll MD</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Loring Byers Funeral Directors 8728 Liberty Rd. Randallstown, Md. 21133</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 12 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 2720 BP.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FREEDMAN ROSE FREEDMAN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-2-1981</b>				
2b. HOUR <b>9-15 PM</b>									
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 15, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BEAMSTRESS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHES</b>	
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MARYLAND</b>					13b. CITY OR TOWN <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13d. STREET ADDRESS <b>APT. D 4001 FORDLEIGH RD. #21215</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>REBCHUL FREEDMAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>212-07-9381A</b>		17. INFORMANT MRS. WILLIAM REISTER <b>MRS. WILLIAM REISTER</b>		
					17. ADDRESS <b>6998 MARSUE DR., APT. 2C #21215</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural hematoma</b> <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>HASCD with Arterial fibrillation.</b>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22. I certify that (I) (this hospital) attended the deceased from <b>5-10-1981</b> to <b>6-2-1981</b> , that (I) (we) last saw the deceased alive on <b>6-2-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R.M. Shah</b> DEGREE									
22c. DATE SIGNED <b>6-2-1981</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.M. SHAH</b>									
22e. ADDRESS <b>B-G-Fe 11600 RD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>									
23b. DATE <b>6/4/81</b>									
23c. NAME OF CEMETERY OR CREMATORY <b>HEBREW YOUNG MEN</b>									
23d. LOCATION <b>BALTIMORE</b> COUNTY <b>KINDSOKMILL</b> STATE <b>MARYLAND</b>									
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b>									
25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>									
25b. ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>									

10-11-11-12

10-11-11-12



10-11-11-12

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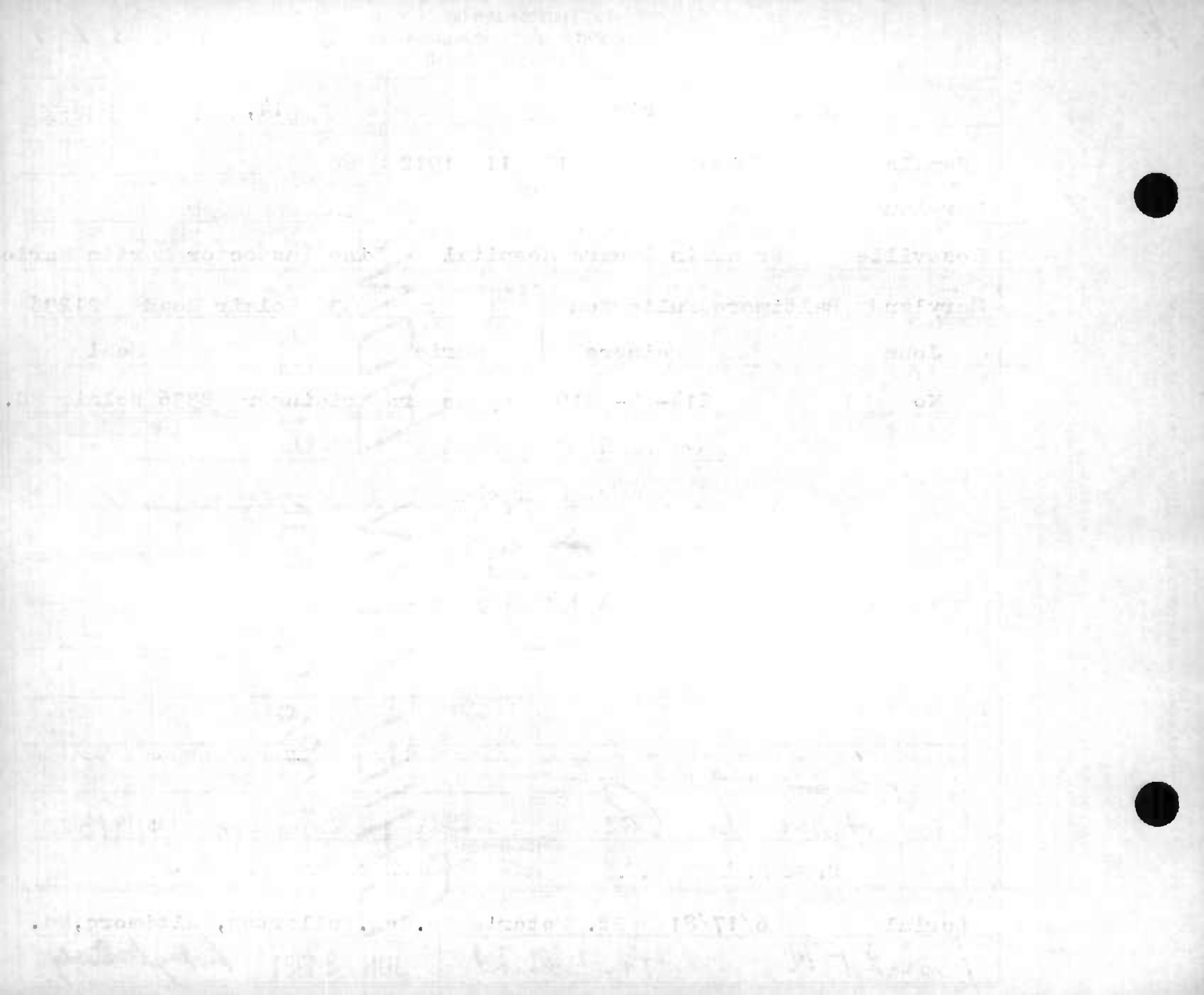
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 6 7 9			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Katherine Marie FRIDINGER								June 14, 1981					12:10A
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		MONTH 12 DAY 11 YEAR 1912		68		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore County						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Rossville		Franklin Square Hospital		Line Inspector		Martin Marie							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Baltimore		Fullerton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8336 Belair Road				21236	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST John Reiners		FIRST MIDDLE LAST Marie Mehl											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		414-22-9919		Ray Howard Fridinger		8336 Belair Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Cardiopulmonary arrest													
5199 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic chest disease													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Involutional depression													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from May 6, 1981, to June 14, 1981, that (we) last saw the deceased alive on June 14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We would) (do not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Diane A. Lowe, M.D.		9000 Franklin Square Dr., 21237											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		6/17/81		St. Peter's Ch. Cem.		Fullerton, Baltimore, Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Lassahn F.A.		7401 Belair Rd.		JUN 18 1981									

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 8 0							
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR							
FIRST MIDDLE LAST Nora A Garbe					MONTH DAY YEAR 6 15 81					8:45 AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
female		Caucasion		MONTH DAY YEAR 7 17 1888		92 yrs.		YRS. MONTHS DAYS 8		HOURS MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore, Md.		USA				Towson MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Towson		Stella Maris Hospice				Rt Saleslady		unknown									
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5206 Leith Road. 21239						
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST Conrad Garbe					FIRST MIDDLE LAST Mary Ellen Dee												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS										
no					215 24 0565		Stella Maris Hospice										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>recent Cerebral Vascular Accident</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
														YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6-19</u> , 19 <u>78</u> , to <u>6-15</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6-15</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE <u>Eddie Nakhuda</u> DEGREE		22c. DATE SIGNED <u>6-15-81</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS											
Dr. Eddie Nakhuda						Stella Maris Hospice											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				6/17/81		New Cathedral Cemetery				Baltimore Md.							
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Mitchell-Wiedefeld Home 6500 York Rd.						JUN 18 1981		<u>R. A. R.</u>									

377 8300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 6 8 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) George William Gardner, Jr.				2a. DATE OF DEATH June 4, 1981		2b. HOUR 1 p. M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 22, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10 D Richmar Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Gas Light Co.	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Owings Mills	
14. FATHER'S NAME George W. Gardner				15. MOTHER'S MAIDEN NAME Jessie Foot			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577-07-7284		17. INFORMANT Mary Gardner	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C.V.A.</u> 2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Consequential Heart Failure</u> (c) <u>Diabetic Mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>78 hours</u> <u>26 years</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20/79</u> 19 <u>79</u> to <u>6/4/81</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/3</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Edwin L Pierpont, MD</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/5/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWIN L PIERPONT, MD				22e. ADDRESS 8704 LIBERTY Rd BALTO. 21207 MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE June 5, 1981		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR <u>H. E. Schmitt</u>				25a. DATE REC'D. BY REGISTRAR JUN 9 1981		25b. REGISTRAR'S SIGNATURE <u>Barney Liberty</u>	



Items #18a-22a Film G557 7/7/81 reSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
EDITH H. GARRISON								X		6		7		19		81	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
female	white	7 21 06		74		YRS.				6		7		19		81	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Georgia		U.S.A.										Baltimore County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Towson		Greater Balto. Medical Center		Supervisor		Hospital											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Balto.				YES <input type="checkbox"/> NO <input type="checkbox"/>		400 Georgia Ct 21204									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
John A. Hoke		Marion Wilson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		216-18-0515A		Mrs. Regina Toone Columbus, N.J.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		Acute salicylate intoxication		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
9800		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		ADD. ONLY <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		? P.M. 6/7/ 19 81		Ingested drugs													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		400 Georgia Ave. City of Towson Balto Co. Md.											
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		6-10-81											
Ann M. Dixon, M.D.		Assistant															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Removal		6/11/81															
24. FUNERAL DIRECTOR		NAME		ADDRESS		DATE REC'D. BY REGISTRAR		15 JUN 15 1981									
Anatomy Board				Balto., Md.													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80



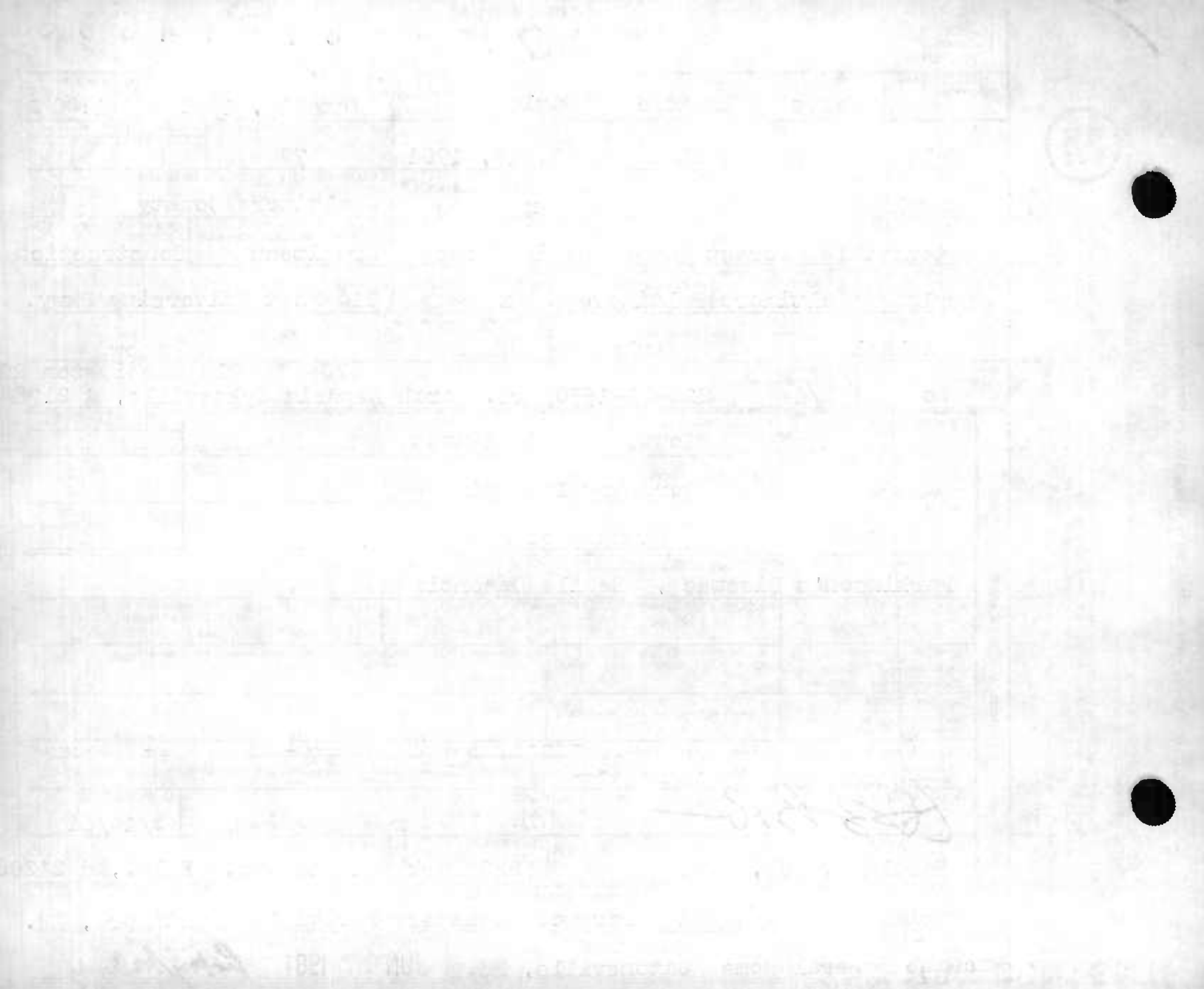
TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5878.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 6 8 3			
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE Hammond			LAST Gaule				
2a. DATE OF DEATH			MONTH June			DAY 15,			YEAR 1981				
2b. HOUR 1:40 PM													
3 SEX Male			4 RACE Caucasian			5 DATE OF BIRTH MONTH DAY YEAR Sept. 17, 1901			6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10 CITY OR TOWN OF DEATH Catonsville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Forest Haven Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect		12b. KIND OF BUSINESS OR INDUSTRY Construction		
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 116 West University Pkwy.	
14 FATHER'S NAME FIRST MIDDLE LAST Michael Gaule			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Snow			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) N/A			17 INFORMANT 6205 ADDRESS Old Washington Rd Mrs. Sarah Lendrim Sykesville, Md 21784	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Heart Attack</u> <u>4100</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>(History of Pacemaker)</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parkinson's Disease, Senile Dementia</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/4/81</u> to <u>6/15</u> , 19 <u>81</u> , that (I) <input checked="" type="checkbox"/> saw the deceased alive on <u>6/4/81</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.													
22b. SIGNATURE <u>Harold B. Bob</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 6/16/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harold B. Bob, M.D.			22e. ADDRESS 7220 Park Heights Ave. Balt., Md 21208										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/17/81			23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore, Md.				
24 FUNERAL DIRECTOR NAME MacNabb Funeral Home			ADDRESS Catonsville, Md.			25a. DATE REC'D. BY REGISTRAR JUN 17 1981			25b. REGISTRAR'S SIGNATURE <u>Robert H. Brady</u>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>HILDA S. GAY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 26, 1981</b>			2b. HOUR <b>8:45A.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 5 1884</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Del</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>DULANEY TOWSON NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret School Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		
13a. STATE <b>Md.</b>					13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Spear</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Etta Hill</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>013-01-3047</b>		17. INFORMANT ADDRESS <b>Andrew N. Sherman Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC STANDSTILL</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>CORONARY HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT.</b> <b>INSTANT.</b> <b>YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 1980</b> to <b>JUNE 1981</b> , that (I) (we) lost saw the deceased alive on <b>6/12/81</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>FOR SIDNEY VENABLE, M.D. Donald L. Somerville, M.D.</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/26/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD L. SOMERVILLE, M.D.</b>						22e. ADDRESS <b>26 W. PA. AVE TOWSON, MD 21206</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>6/29/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd.</b>						25. FILED IN REC'D BY REGISTRAR <b>JUN 30 1981</b>				

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Handwritten notes and stamps on the right margin, including a large circular stamp.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GENEVIEVE</b>		FIRST MIDDLE LAST <b>GERCZAK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>06-01-81</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 01 99</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
10. CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RIVERVIEW NURSING CENTRE, INC</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>ESSEX</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANCES NOWICKI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOSEPHINE RYGLEWICZ</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 01 0110A</b>		17. INFORMANT ADDRESS <b>Eugene J. Gerczak Same as above</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of urethra</b> 1893 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11-6-80</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1-5-81</b> , 19 <b>81</b> , to <b>6-1-81</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6-1-81</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>B.W. SOLLOD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-1-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B.W. SOLLOD</b>		22e. ADDRESS <b>2900 DUNRAV RD 21222</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/5/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 5 1981</b>			
24. FUNERAL DIRECTOR NAME <b>DIPPEL FUNERAL HOMES INC.</b>		ADDRESS <b>7110 BELAIR RD. 21206</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 20 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	1	4	6	8	6
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>MARIE B. GIVANS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 22 81</b>					2b. HOUR <b>705 AM</b>						
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 22 94</b>			6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.								
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Old Court Nursing Home 5412 Old Court Rd.</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>3107 Huntington Ave.</b>							
14 FATHER'S NAME FIRST MIDDLE LAST <b>James H. Brown</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara E. Grant</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO <b>213-10-3077</b>		17 INFORMANT ADDRESS <b>Mrs. Marie Gable 7115 Oxford Rd. Balto.</b>									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Atherosclerotic Cardio-Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerotic Cardio-Vascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>1979</b> 19____, to <b>JUNE 22 81</b> 19____, that (I) (we) last saw the deceased alive on <b>JUNE 22 81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
23a. SIGNATURE <b>Ramon S. Pimentel, MD</b>					DEGREE <b>MD</b>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED <b>June 22/81</b>				
23b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAMON S. PIMENTEL, JR.</b>					23d. ADDRESS <b>7501 LIBERTY ROAD, BALTO. MD</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>6/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Mem. Bdns.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Carroll County Md.</b>						
24 FUNERAL DIRECTOR NAME <b>A. Alan Seitz, Jr.</b>					ADDRESS <b>3818 Roland Ave.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner (must be marked) must be notified.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BERTRAM</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 24, 1981</b>			2b. HOUR A <b>2:12 M</b>		
3. SEX <b>MALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 2, 1913</b>		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>			10. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>			11. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MARYLAND</b>			12b. COUNTY <b>BALTO.</b>			12c. CITY OR TOWN <b>BALTIMORE</b>		
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13b. STREET ADDRESS <b>3302 ROLLING RD. #21207</b>			13c. STREET ADDRESS <b>3302 ROLLING RD. #21207</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEXANDER GOCHRACH</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH KOHN</b>			16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>SARAH KOHN</b>		
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			17b. SOCIAL SECURITY NO. <b>WNT-NAVY 216-01-4579</b>			17c. INFORMANT <b>C. MORTON GOLDSTEIN</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Severe Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>over 4 yr</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>over 4 yr</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>none</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>81</b> , to <b>6/23/81</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>George M. Ramapuram, MD.</b>			DEGREE			22c. DATE SIGNED <b>6/24/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE M. RAMAPURAM, MD.</b>			22e. ADDRESS <b>3502 CROYDON ROAD</b>			22f. ADDRESS <b>3502 CROYDON ROAD</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>6/29/81</b>			23c. NAME OF CEMETERY OR CREMATORY <b>LOUDEM PARK</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			23e. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			23f. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1981</b>			25b. REGISTRAR'S SIGNATURE <b>John J. McCreedy</b>		

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OFFICE OF THE ATTORNEY GENERAL



RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

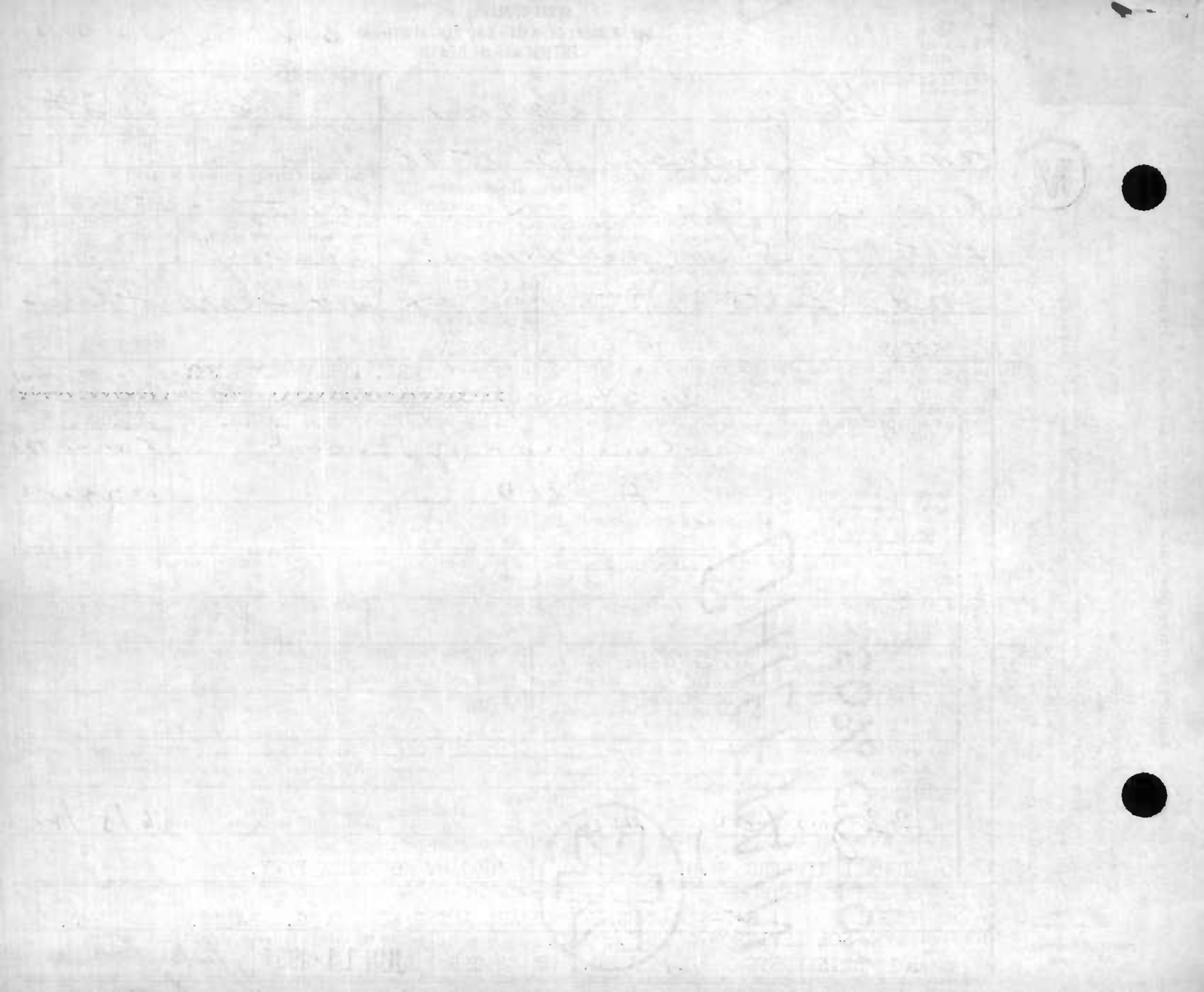
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Goldstein Goldstein			2a. DATE OF DEATH MONTH DAY YEAR 6 5 81		2b. HOUR 3:30 PM
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 12 15 88		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia	7b. CITIZEN OF WHAT COUNTRY? Yes	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County - BALTIMORE MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Jewish Center N. Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY AT HOME
13a. STATE md		13b. CITY OR TOWN BALTIMORE	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS #21209 6114 Benhurst Rd	
14. FATHER'S NAME FIRST MIDDLE LAST OSCAR WISE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-54-1120		17. INFORMANT MRS. EVELYN RAMINSKY	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 1519 DUE TO, OR AS A CONSEQUENCE OF (b) A SHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) 6114 BENHORST RD. BALTO., MD 5 months 14 years					INTERVAL BETWEEN DEATH AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Israel Zinberg MD		DEGREE		22c. DATE SIGNED 6/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ISRAEL ZINBERG M.D.		22e. ADDRESS 4000 W. NORTHERN PKWY.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6-7-81		23c. NAME OF CEMETERY OR CREMATORY KNESSETH ISRAEL ANSHE KOLK CONG. BALTO. MD.	
23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215			
25a. DATE REC'D. BY REGISTRAR JUN 11 1981		25b. REGISTRAR'S SIGNATURE Isabel McBrady			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST <b>LEWIS RICHARD GOULD</b>			MONTH DAY YEAR <b>6 15 81</b>			5:10 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
<b>MALE</b>	<b>WHITE</b>	MONTH DAY YEAR <b>05 05 04</b>	<b>77 YRS</b>			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
<b>PENNSYLVANIA</b>	<b>U.S.A.</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
<b>RANDALLSTOWN</b>	<b>BALTIMORE COUNTY GENERAL HOSP.</b>			<b>ACCOUNTANT</b>			<b>WESTINGHOUSE</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
<b>MARYLAND</b>	<b>BALTIMORE</b>	<b>RANDALLSTOWN</b>	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	<b>3432 CARRIAGE HILL CIRCLE, 21133</b>				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
<b>LEWIS R. GOULD</b>			<b>NETTIE E. WELSHONS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
<b>NO</b>			<b>166-10-0295</b>		<b>RUTH C. GOULD 3432 CARRIAGE HILL CIRCLE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COMP</b> <b>4274</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIAC ARREST</b> Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>VENTRICULAR FIBRILLATION</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>HYPER TENSION</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<b>Hafeez A Syed</b>						<b>6/15</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
<b>HAFAEEZ A SYED M.D.</b>			<b>BALTIMORE COUNTY GEN HOSP.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>BURIAL</b>			<b>06-18-81</b>		<b>LOUDON PARK</b>		<b>BALTIMORE CITY MARYLAND</b>	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
<b>HUBBARD FUNERAL HOME, INC.</b>			<b>4107 WILKENS AVE.</b>			<b>21229</b>		<b>JUN 17 1981</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

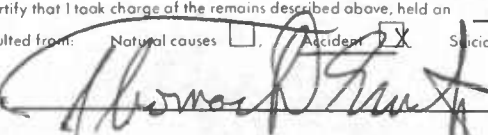



RECEIVED  
JAN 11 1964  
FBI - NEW YORK

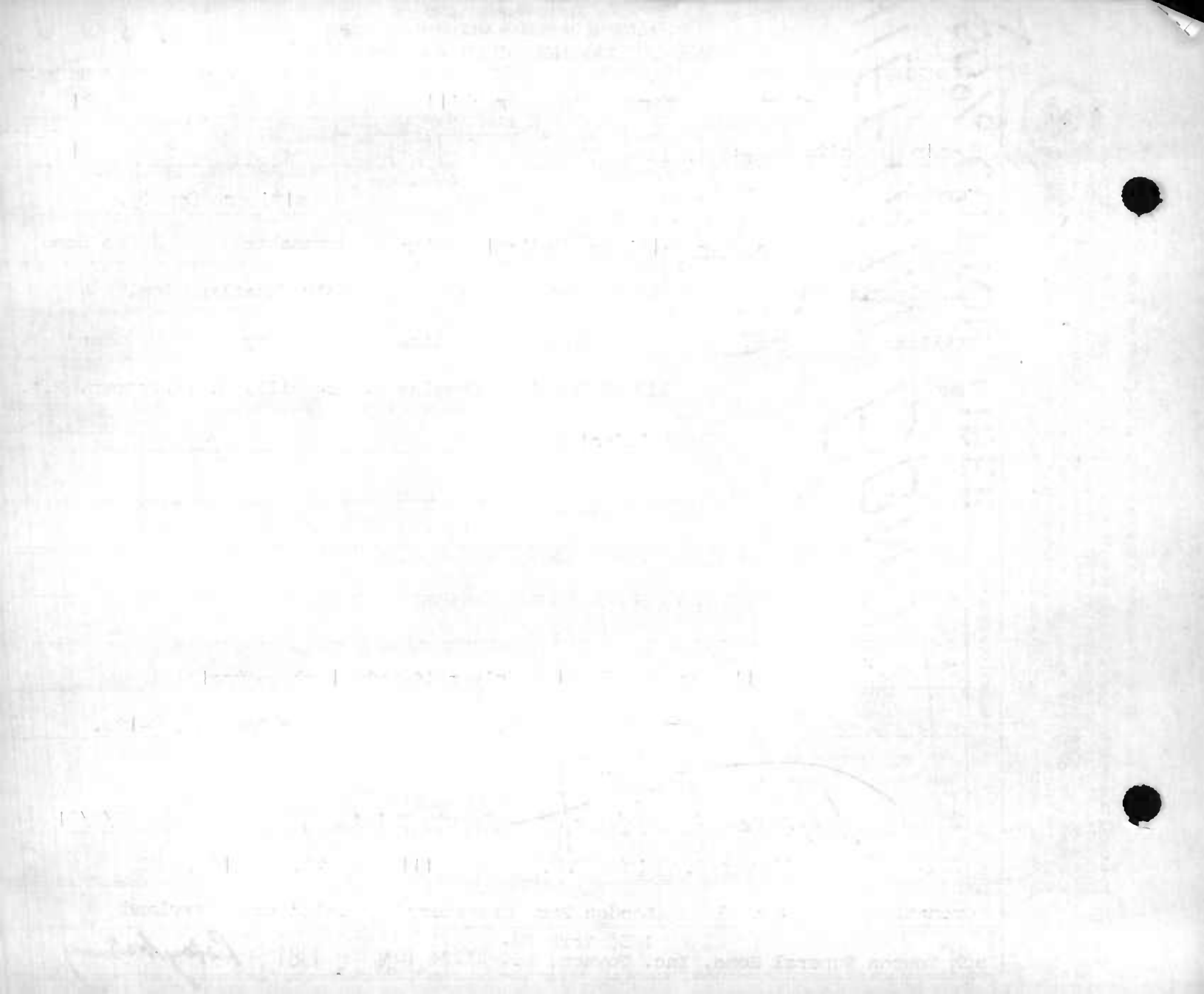
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME(5))  
15M 2/80

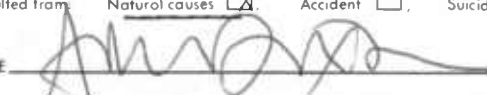
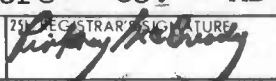
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14690	
1. DECEASED NAME (TYPE OR PRINT) <b>Marietta Mary M. Graybill</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>3</b> YEAR <b>1981</b>		2b. HOUR <b>3:32P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>16</b> YEAR <b>1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		7. IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>3</b> YEAR <b>1981</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County,</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Pennsylvania</b>				13b. CITY OR TOWN <b>York</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1310 Wheatland Ave.</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>H.</b> LAST <b>Moore, Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>May</b> LAST <b>Bond</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>212-01-2074A</b>		17. INFORMANT ADDRESS <b>Douglas M. Graybill, N. Kingstown, R.I.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chest injuries</b> <b>8160</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:25xx 6 3 1981</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver of auto lost control!</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>		21f. LOCATION STREET <b>Rt. 83</b> CITY OR TOWN <b>Parkton</b> COUNTY <b>Balto.</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>6/4/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>6-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Maryland</b> COUNTY <b></b> STATE <b></b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> ADDRESS <b>1050 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 5 - 1981</b>		25b. REGISTRAR'S SIGNATURE 			





Items #5&6 Film G556 6/18/81 rc  
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE GREEN</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 5 1981</b>		2b. HOUR M <b>5:20</b>
3. SEX <b>male</b>	4. RACE <b>negro</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 31 1926</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>54</b>	7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. <b>5 1 19</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hondoras</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore Co. General Hospital</b>
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				
13a. STATE <b>MD</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Lohearan</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>3104 St. Lukes Lane</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Percy Green</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Wilhelmia</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-36-1347</b>		17. INFORMANT ADDRESS <b>Sarah M. Green 3104 St. Lukes Ln.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive cardiovascular disease</b> <b>4029</b> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED <b>6-6-81</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/11/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>King Memorial Park</b>	
24. FUNERAL DIRECTOR NAME <b>Wm. C. March F/H</b>		ADDRESS <b>1101 E. North Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 9 - 1981</b>
25b. REGISTRAR'S SIGNATURE 		25c. REGISTRAR'S TITLE <b>Registrar</b>		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FREE SHIP BOWT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3. THIS IS TO BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14692	
1. DECEASED NAME (TYPE OR PRINT) John Israel Green						2b. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6 30 1981		2d. HOUR 8:20		2e. MINUTE 20	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR April 9, 1955		6. AGE (IN YEARS) (LAST BIRTHDAY) 26 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.					
10. CITY OR TOWN OF DEATH Owings Mills		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rosewood State Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. CITY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 611 Dolphin Street			
14. FATHER'S NAME FIRST MIDDLE LAST Israel Green						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Alston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT Rosewood Records				ADDRESS Owings Mills, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Seizure disorder 7803 IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) } DUE TO, OR AS A CONSEQUENCE OF (c) }										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 7/1/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE July 8, 81		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.			
24. FUNERAL DIRECTOR Eliehe Funeral Home						ADDRESS Reisterstown, Md. 21136		25a. DATE REC'D. BY REGISTRAR JUL 10 1981		25b. REGISTRAR'S SIGNATURE	



DHMH - 16 50M 1/81  
(VRA 15, 4)

FOR  
STATE  
REGISTRAR XC 04 657 479

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
GEORGE		CLEMENT		GREENLEAF				JUNE 12, 1981								8:20 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
MALE		WHITE		JUNE 2, 1914		67		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
NEW YORK		U.S.A.				BALTIMORE COUNTY											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
FORT HOWARD		V.A. MEDICAL CENTER		GUARD		VA Hospital											
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1421 ELMTREE STREET											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST		FIRST MIDDLE LAST															
GEORGE S. GREENLEAF		AGNES D. DRISCOLL															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		WWII		115 01 2315		CLINICAL RECORDS, VAMC, FORT HOWARD, MD											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY:		MINUTES															
IMMEDIATE CAUSE (a) ASPIRATION																	
4920																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		YEARS															
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from JUNE 10, 19 81, to JUNE 12, 19 81, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on JUNE 12, 19 81, and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (I/we) (did) (did not) view the body after death.																	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED													
CAROLINA CUSTODIO, M.D.		M.D.		6/12/81													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS															
		V.A.M.C. FORT HOWARD, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial		6/15/1981		Glen Haven Mem. Pk.		Glen Burnie, A.A., Md.											

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UNITED STATES DEPARTMENT OF JUSTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

Item 7a g556 6/19/81 g3												STATE OF MARYLAND											
1- FOR STATE REGISTRAR												DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. DECEASED NAME (TYPE OR PRINT) <b>SAMUEL H. Gressitt</b>												2a. DATE OF DEATH MONTH DAY YEAR <b>June 7, 1981</b> 2b. HOUR <b>4:40</b> P.M.											
3. SEX <b>male</b>				4. RACE <b>white</b>				5. DATE OF BIRTH MONTH DAY YEAR <b>9 21 1885</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.											
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baptist Home of Maryland</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Resident</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Retirement H.</b>											
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>BALTIMORE</b>				13c. CITY OR TOWN <b>BALTIMORE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>301 MC MECHEN ST.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John M. Gressitt</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida A. Lyell</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>217-40-8722</b>				17. INFORMANT ADDRESS <b>BAPTIST HOME OF MD.</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Probable myocardial infarct</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b>																							
DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Febrile viral illness</b>																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION CITY OR TOWN COUNTY STATE															
22a. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1978</b> to <b>June 7, 1981</b> , that (I) (we) lost saw the deceased alive on <b>June 7, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE <b>Rolando Vieta MD</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED <b>4/7/81</b>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando Vieta</b>												22e. ADDRESS <b>11 E Chestnut Hill La Reisterstown</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 11, 1981</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn, Balto. Co., Md.</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto., Md.</b>												25a. DATE REC'D BY REGISTRAR <b>JUN 12 1981</b> REGISTRAR'S SIGNATURE											

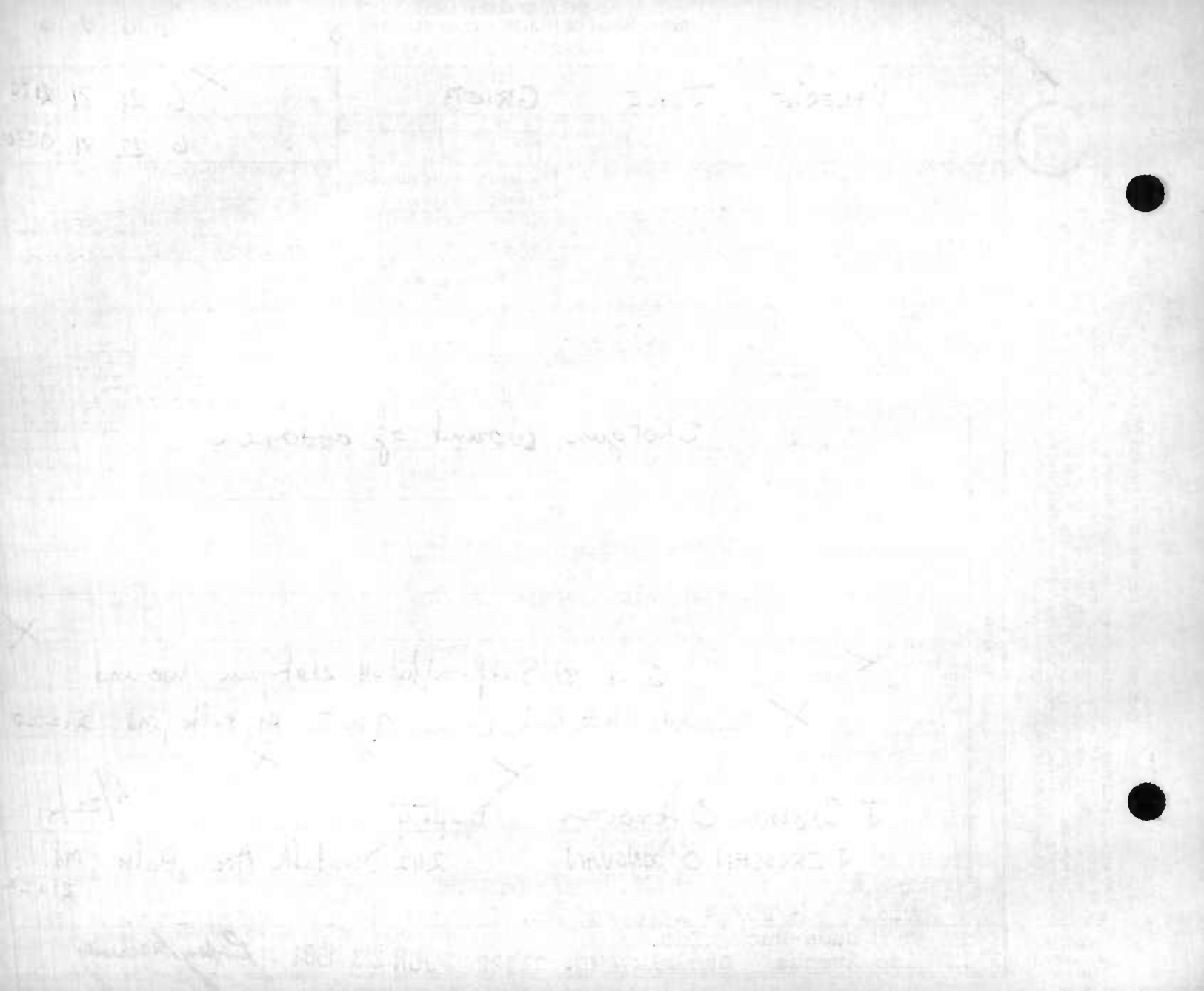


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14695					
1. DECEASED NAME (TYPE OR PRINT) <b>VALERIE JOYCE GRIEB</b>						2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> 6 DAY 21 YEAR 1981		2b. HOUR 2130 AM							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 26 45</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>35 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 22 1981</b>		7d. HOUR 0330 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>		MD.	
10. CITY OR TOWN OF DEATH <b>Middle River</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Grace's Quarters Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>				12b. KIND OF BUSINESS <b>Bd. of Ed. Balto. City</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7217 Shipway</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cornelius B. McMichael</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Blum</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-44-5226</b>		17. INFORMANT <b>Frank H. Grieb</b>				ADDRESS <b>7217 Shipway Balto., MD. 21222</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9554 Shotgun wound of abdomen</b> IMMEDIATE CAUSE (a) <b>Shotgun wound of abdomen</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6 21 1981</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Self-inflicted shotgun wound</b>							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Gimpowder State Park, Grace's Quarters Rd, Balto., Md. 21220</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Baltimore, Md. 21220</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>6/22/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>				ADDRESS <b>242 Dundalk Ave., Balto., Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/25/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Ht. Of Jesus</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD. 21222</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Barbara K. Brady</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-2727.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 6 9 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GLADYS M. GRIFFIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 26 '81</b>		2b. HOUR <b>3:50A<sub>M</sub></b>	
3. SEX <b>FEMALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 3 '18<sup>AR</sup></b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE MAIN STREET, CITY, STATE, AND ZIP CODE) <b>GBMC-6701 N. CHARLES ST.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DRUG MFG.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>424 N. HILTON ST.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>NATHAN BULTER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATIE WASHINGTON</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>218 09 2725</b>	
17. INFORMANT ADDRESS <b>GLORIA SAYLES 2000 ODELL AVE.</b>		18. CITY OR TOWN <b>BALTIMORE, MD.</b>		19. ZIP CODE <b>21237</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-PULMONARY FAILURE</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CA OF THE OVARIES</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/3</b> <b>81</b> to <b>6/26</b> <b>81</b> , that (I) (we) last saw the deceased alive on <b>6/26</b> <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Carter J. Williams</i> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARTER J. WILLIAMS, M.D.</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/26/81</b>	
22d. ADDRESS <b>GBMC-6701 N. CHARLES ST.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARBUTUS MEMORIAL PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE, MD. 21227</b>	
24. FUNERAL DIRECTOR <i>Marshall R. Higgins</i> 24. FUNERAL DIRECTOR'S NAME (TYPE OR PRINT) <b>Marshall R. Higgins</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia M. Hickey</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 6 9 7		
1. FOR STATE REGISTRAR		CERTIFICATE OF DEATH								REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN		MIDDLE W.		LAST GRIFFITH		2a. DATE OF DEATH MONTH DAY YEAR 06 22 81		2b. HOUR 11 <sup>00</sup> A <sup>M</sup>		
3. SEX MALE		4. RACE CAUCASION		5. DATE OF BIRTH MONTH DAY YEAR 03 28 98		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.						
10. CITY OR TOWN OF DEATH Randallstown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking				
13a. STATE Md		13b. COUNTY -		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1323 Union Avenue				
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Griffith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie May Gilly								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212 07 5048		17. INFORMANT Louise S. Griffith				ADDRESS SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO-SCLEROTIC HEART DISEASE &amp; FAILURE</u> (c) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>6-18-</u> 19 <u>81</u> , to <u>6-22-</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6-22-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>[Signature]</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/22/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR PATEL				22e. ADDRESS Bal. County Gen. Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/25/81		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto. Md						
24. FUNERAL DIRECTOR NAME Burgee Funeral Home				3631 Falls Road		21211		25a. DATE REC'D. BY REGISTRAR JUN 24 1981		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		





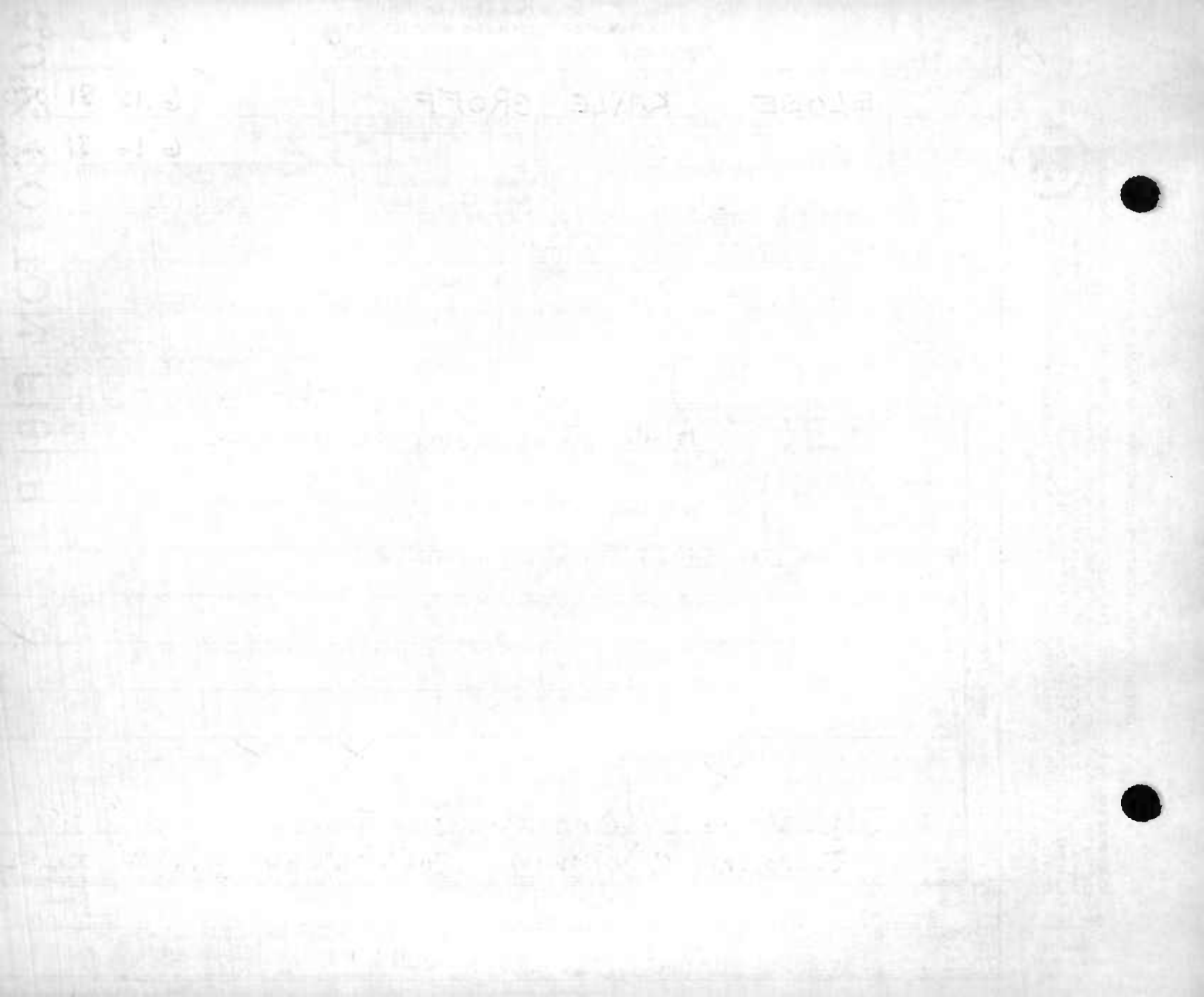
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14698	
1. DECEASED NAME (TYPE OR PRINT) <b>ELOISE KARLE GROFF</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 16 1981</b>		2b. HOUR <b>0300</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 2 1914</b>		6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>66</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>6 16 1981</b>		7d. HOUR <b>0945</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Ft. Howard</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7514 Blank Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Ft. Howard</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7514 Blank Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Groff</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma C. Wertheimer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218-30-9848</b>		17. INFORMANT ADDRESS <b>Addie E. Pettie- Ft. Howard, MD. 21052</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Acute intracerebral hemorrhage</b> <b>4310</b> IMMEDIATE CAUSE (a) <b>4310</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>						TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>						ADDRESS <b>2112 Dundalk Ave., Balb. Md. 21222</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/19/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>						ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>H. H. H. H.</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar. Page 4 may be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) WILLIAM R GUISE					2a. DATE OF DEATH MONTH DAY YEAR 6/26/81					2b. HOUR 10:15 P M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 26 45		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TOWSON BALTO. CO. MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 N. CHARLES ST GBMC				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICE OFFICER		12b. KIND OF BUSINESS OR INDUSTRY BALTO CO.			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY BALTO 13c. CITY OR TOWN ESSEX					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 444 STEMMERS RUN				
14. FATHER'S NAME FIRST MIDDLE LAST STUART GUISE, SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE RICHARDSON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WET 212-48-8943		17. INFORMANT ADDRESS DENISE GUISE 444 STEMMERS RUN				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPSIS 2019 DUE TO, OR AS A CONSEQUENCE OF (b) APLASTIC ANEMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF HODGKINS STAGE IV B										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JUNE 18 81, to JUNE 26 81, and that (I) (we) lost the deceased alive on JUNE 26 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE BRIAN ADLER				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 6/26/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR BRIAN ADLER				22e. ADDRESS GBMC							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 6-30-81		23c. NAME OF CEMETERY OR CREMATORY ZION LUTHERAN CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE, MARYLAND			
24. FUNERAL DIRECTOR NAME CONNELLY FUNERAL HOME				ADDRESS 300 MACE AV		25a. DATE REC'D. BY REGISTRAR JUL 2 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

SECRET  
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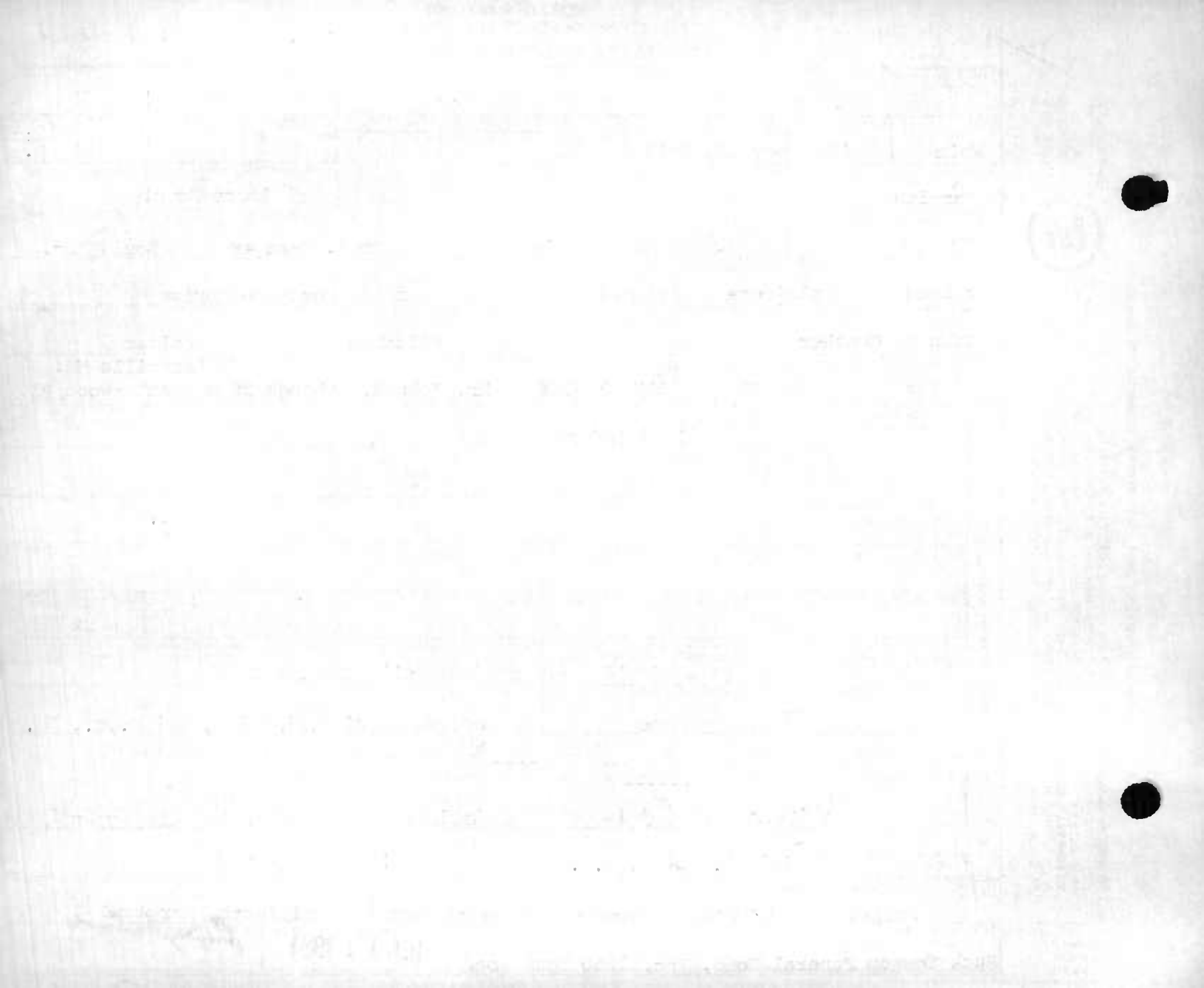
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE GENERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14700	
1. DECEASED NAME (TYPE OR PRINT) <b>John Gunther</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <b>6 14 19 81</b>			2b. HOUR <b>12:20 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 10, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> RS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>6 14 19 81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Timonium</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>54 Northwood Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Prod. Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Gould Ind.</b>	
13a. STATE <b>Maryland</b>				13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>54 Northwood Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John F. Gunther</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Felter</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				(IF YES, GIVE WAR OR DATES) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>217-07-0764</b>		17. INFORMANT ADDRESS <b>Mr. John G. Arbaugh 28 B Leatherwood Pl. Rossville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blunt injury to head</b> 8809 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 6 14 19 81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject fell down steps</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>54 Northwood Drive, Timonium, Balto. Co., Md.</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Virginia L. Dolan</b>						TITLE (SPECIFY) <b>M.D. Assistant</b>		MEDICAL EXAMINER		DATE SIGNED <b>6-15-81</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>						ADDRESS <b>111 Penn Street</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6/17/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>		25b. <b>[Signature]</b>			

MEDICAL CERTIFICATION





3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8114701	
1. DECEASED NAME (TYPE OR PRINT) <b>Katie Veenstra Hagedoorn</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 27, 1981</b>			2b. HOUR <b>8:35A M</b>			
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 22, 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chapel Hill Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>17-12 Powder Mill Rd. 20903</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Conrad Veenstra</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Struck</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Silver Spring, Md. 20903</b> <b>Anthony W. Hagedorn 17-12 Powder Mill Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 4</b> , 19 <b>79</b> , to <b>June 27</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>June 27</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Martin E. Strobel</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-27-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin E. Strobel, M.D.</b>				22e. ADDRESS <b>59 Hanover Road Reisterstown, Maryland 21136</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fair Lawn Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fair Lawn Bergen New Jersey</b>			
24. FUNERAL DIRECTOR NAME <b>8728 Liberty Rd, Randallstown, Md.</b> <b>Loring Byers Funeral Directors, P.A. 21133</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>					

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• • • To quote, Gibbon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 7 0 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
FLORENCE C		HAIFLEY						6-30-81					4 15 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 4 HRS			
FEMALE		WHITE		5 23 1907		74 YRS		MONTHS		DAYS		HOURS MIN	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md		U.S.A.				BALTIMORE		CO.				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Randallstown		Baltimore Co General		TELLER		BANK							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		CARROLL		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		149 E. Main					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
John Edward Powell		Sadie Dukes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
NO		218-03-7062		Wm. F. Haifley		Westminster, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4360		old and new cerebro-vascular accident								weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET									
22a. I certify that (I) (this hospital) attended the deceased from 6-25-19-81 to 6-30-19-81, that (I) (we) lost saw the deceased alive on 6-30-19-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
		Soonchul Hong				6-30-81							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
SOONCHUL HONG		Baltimore County General Hospital											
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL		7-3-81		BAUST		Westminster		CARROLL		MD			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Robert E. Pithers Jr. Westminster, Md.		JUL 9 1981											

THURSDAY 18-3-81

Westminster Canal and

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 Baltimore Co General  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
John Thomas HAINES			June 19, 1981			2:25 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
M	W	5/11/23	58 YRS.			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
MD.			USA			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
ROSSVILLE			FRANKLIN SQ.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
MD.			BALTO			59 SELFRIDGE RD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
THOMAS W. HAINES			AMELIA HARDEN			16b. SOCIAL SECURITY NO.		
						219 125285		
						17. INFORMANT		
						VIOLET HELWIG ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Coma; hypotension and sepsis								
4292 DUE TO, OR AS A CONSEQUENCE OF Chronic renal failure; history of high blood pressure; bilateral above knee amputation								
DUE TO, OR AS A CONSEQUENCE OF Severe arteriosclerotic cardiovascular disease;								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):								
Severe peripheral vascular disease								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
		HOUR A.M. MONTH DAY YEAR		19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (X) (this hospital) attended the deceased from June 17, 19 81, to June 19, 19 81, that (X) (we) lost saw the deceased alive on June 19, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.								
22b. SIGNATURE				DEGREE				22c. DATE SIGNED
Juliana Chyu				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				6/19
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
Juliana Chyu				9000 Franklin Square Dr., 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL		6/22/81		HOLLY HILL		BALTO. COUNTY MD.		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.G. CONNELLY				300 MACE		JUN 23 1981		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

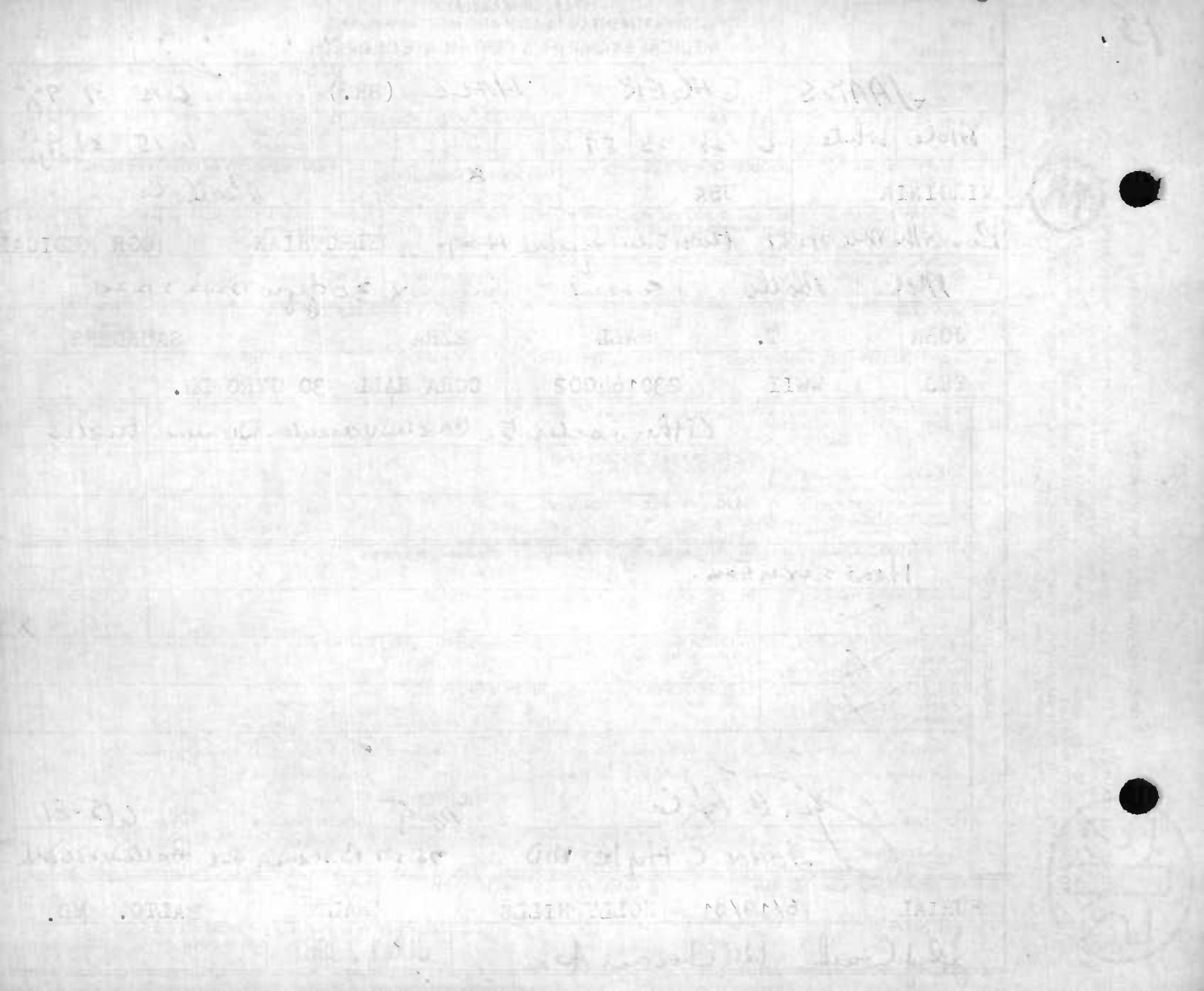
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FOR  
1- STATE REGISTRAR  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES SAGER</b>		FIRST <b>HALL</b>		LAST <b>(SR.)</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>6 15 81</b>		2b. HOUR <b>9:50</b> M <b>PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 28 23</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>57</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD <b>6 15 81</b>		2d. HOUR <b>9:50</b> M <b>PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto Co</b>		MD	
10. CITY OR TOWN OF DEATH <b>Romville Md 21087</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NONE, GIVE FACILITY, GIVE STREET ADDRESS) <b>Thurston Square Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ELECTRIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OGR MEDICAL</b>			
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Annet</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>30 Gyro Drive 21220</b>	
14. FATHER'S NAME FIRST <b>JOHN</b> MIDDLE <b>T.</b> LAST <b>HALL</b>		15. MOTHER'S MAIDEN NAME FIRST <b>EZRA</b> MIDDLE <b>SAUNDERS</b> LAST <b>SAUNDERS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>230164002</b>		17. INFORMANT ADDRESS <b>CORA HALL 30 GYRO DR.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>undet</b>		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Heat &amp; exertion.</b>		19a. DATE OF OPERATION <b>X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>J. C. Hyle</b>		TITLE (SPECIFY) <b>MD</b>		MEDICAL EXAMINER <b>John C. Hyle MD</b>		DATE SIGNED <b>6-15-81</b>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <b>7527 Belvoir Rd Balto 21236 Md</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/19/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILLS</b>	
24. FUNERAL DIRECTOR NAME <b>J. C. Hyle</b> ADDRESS <b>1211 Chesapeake Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 19 1981</b>		25b. REGISTRAR'S SIGNATURE <b>John C. Hyle</b>					
23d. LOCATION CITY OR TOWN <b>BALTO</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8114705			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST PEARL G. HALL				2a. DATE OF DEATH MONTH DAY YEAR 6 17 81			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 1 04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Summit Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Paint Co. Davis	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Baltimore			
13c. CITY OR TOWN Arbutus				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Walter Keilholtz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Howard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-03-1422		17. INFORMANT ADDRESS 12127 Leeds Terrace Balto., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 1830 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Metastatic adenocarcinoma of</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>the way</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from 5/16/81 to 6/17/81, that (1) (we) lost saw the deceased alive on 6/17/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (I) (did) (did not) view the body after death.)							
22b. SIGNATURE Herbert J. Levickas MD				22c. DATE SIGNED 6/17/81		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Herbert J. Levickas				22f. ADDRESS 5404 East Drive (21227)			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/81		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Pk A.A. Co. Md.	
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Balto., Md. 21229				25a. DATE REC'D. BY REGISTRAR JUN 18 1981		25b. REGISTRAR'S SIGNATURE Fitzroy McBrady	

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Handwritten signature

JUN 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH-16 25M  
(VRA 15, 4) 1/79TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 4 7 0 6	
FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			
FIRST MIDDLE LAST Guy G. HARBAUGH			MONTH DAY YEAR June 15, 1981			
3. SEX Male			2b. HOUR M			
4. RACE White						
5. DATE OF BIRTH MONTH DAY YEAR October 12, 1919			6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS			
7a. CITIZEN OF WHAT COUNTRY? U.S.A.			7b. IF UNDER 1 YEAR MONTHS DAYS			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital			
12. CITY OR TOWN OF DEATH Randallstown			13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter-Franklin Realty			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. CITY OR TOWN Baltimore			
13c. CITY OR TOWN Balto. County			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 6612 Fairmount Avenue 21215						
14. FATHER'S NAME FIRST MIDDLE LAST Guy I. Harbaugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary S. Boring			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. W W 11 216-05-9013			
17. INFORMANT Mrs. Nancy Claggett			18. ADDRESS 108 Red Pump Rd. Belair, MD. 21014			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4/140 Cardio-pulmonary arrest 2° to DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) ASHD CHF, Renal Insufficiency						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5-29-1981 to 6-15-1981, that (I) (we) last saw the deceased alive on 5-15-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE R.M. Shah M.D.		DEGREE		22c. DATE SIGNED 6-15-1981		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.M. SHAH M.D.		22e. ADDRESS Old Court S. 116m RD B.C. GH RANDALLSTOWN				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/18/81		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery Woodlawn Baltimore MD.		
23d. LOCATION CITY OR TOWN COUNTY STATE						
24. FUNERAL DIRECTOR Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, MD. 21133		25a. DATE RECEIVED BY REGISTRAR JUN 18 1981		25b. REGISTRAR'S SIGNATURE		



*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

11-21-2

11-21-2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	7	0	7			
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Kenneth Allen Hartmann</b>										2a. DATE OF DEATH MONTH <b>6</b> - DAY <b>16</b> - YEAR <b>81</b>									
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH <b>8</b> DAY <b>10</b> YEAR <b>1928</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>			IF UNDER 74 HRS. HOURS <b></b> MIN. <b></b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.										
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Cntr.</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Law Enforcement</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Law Enforcement</b>						
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>			13c. CITY OR TOWN <b>Cockeysville</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>1119 Greenway Road, Cockeysville</b>							
14. FATHER'S NAME FIRST <b>Milton</b> MIDDLE <b></b> LAST <b>Hartmann</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mildred</b> MIDDLE <b>Elizabeth</b> LAST <b>Lehneis</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> <b>Korean</b>					16b. SOCIAL SECURITY NO. <b>214-20-8827</b>				
17. INFORMANT <b>Mrs. Ann S. Hartmann, 1119 Greenway Rd.</b>										ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>1973</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b></b>																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>E. F. Curet, M.D.</b>					DEGREE <b>Info from record of Dr. Curet</b>					22c. DATE SIGNED <b>6/16/81</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lawrence Awalt, M.D.</b>					22e. ADDRESS <b>7401 Osler Drive, Towson, Maryland 21204</b>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>6/20/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>					23d. LOCATION CITY OR TOWN <b>Cockeysville</b> COUNTY <b>Maryland</b> STATE <b></b>							
24. FUNERAL DIRECTOR NAME <b>J. E. Lowell Lemmon</b> ADDRESS <b>10 W. Padonia Rd.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>					25b. REGISTRAR'S SIGNATURE <b>Robert H. Kelly</b>									



1. Name

2. Address

3. City

4. State



5. Zip

6. Phone

7. Signature

8. Date



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 0 8	
1- STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST
James M. Harvey					
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		Nov. 4, 1924	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
South Carolina		U.S.A.		56 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Towson		GBMC 6701 N. Charles St. 21204		Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Accountant		U.S. Govt.			
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland			Baltimore	21234	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
Thomas H. Harvey			Katheryn Ramseyer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT ADDRESS
Yes			W.W. 11		579-38-9645 Dorothy J. Harvey 1811 Deveron Rd.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CAPOD Respiratory Arrest</u> <u>5715</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis and Liver Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Unknown</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Minutes
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/4</u> , 19 <u>81</u> , to <u>6/5/</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>6/5</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Michael B. Grieco</u> DEGREE <u>M.D.</u>		22c. DATE SIGNED 6/5/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Michael B. Grieco, M.D.		6701 N. Charles St. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/8/81		Parkwood Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
William E. Johnson		8521 Loch Raven Blvd. JUN 8 1981		<u>Dorothy Harvey</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8114709			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 2 (Patricie) May Hatfield				2a. DATE OF DEATH MONTH DAY YEAR June 18, 1981			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR September 7, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. 9 M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IS NOT BY SUCH FACILITY, GIVE STREET ADDRESS) 734 N. Avondale Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxis		12b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN Md. Bal To Dundalk				13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 734 N. Avondale Rd	
14. FATHER'S NAME FIRST MIDDLE LAST (Charles) — May				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 243-01-5428		17. INFORMANT ADDRESS James F. Hatfield 734 N. Avondale Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Demolition DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIO SCLEROSIS							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YR 6 YRS 7 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 1947, to June 16, 1981, that (I) (we) last saw the deceased alive on June 14, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William C. Wade, M.D.				DEGREE M.D.		22c. DATE SIGNED 6-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William C. Wade				22e. ADDRESS 138 William Wade Ave Dundalk Md 21222			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/19/81		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H				ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR JUN 17 1981	
				25b. REGISTRAR'S SIGNATURE [Signature]			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14710	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA MARIA HAUGHEY</b>						2a. DATE KNOWN OF DEATH MONTH <b>6</b> DAY <b>3</b> YEAR <b>1981</b>		2b. HOUR <b>0240</b>			
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>2</b> DAY <b>22</b> YEAR <b>1896</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>85</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>3</b> YEAR <b>1981</b>		2d. HOUR <b>0400</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co.</b> MD.					
10. CITY OR TOWN OF DEATH <b>BALTO.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>508 46<sup>TH</sup> ST.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a. STATE <b>MD.</b>						13b. CITY OR TOWN <b>BALTO.</b>		13c. STREET ADDRESS <b>508 46<sup>TH</sup> ST.</b>			
14. FATHER'S NAME FIRST <b>GUSWIN</b> MIDDLE <b>PRINZ</b> LAST <b></b>						15. MOTHER'S MAIDEN NAME FIRST <b>SUSANNA</b> MIDDLE <b>KLINKHAMER</b> LAST <b></b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-16-5155</b>		17. INFORMANT ADDRESS <b>Mrs. Susanna Heinkele - 508 46<sup>TH</sup> ST.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>J. C. Crossan O. Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>		M.D. <b></b> MEDICAL EXAMINER		DATE SIGNED <b>6/3/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>J. C. CROSSAN O. DONOVAN</b>				ADDRESS <b>2112 DUNDALK AVE. BALT., MD.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b>		23d. LOCATION CITY OR TOWN <b>BALTO.</b> COUNTY <b>MD.</b> STATE <b>21222</b>					
24. FUNERAL DIRECTOR NAME <b>Walter Miller</b> ADDRESS <b>7527 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 8 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Walter Miller</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 1 1	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) <b>A.K.A. Catherine Haupt</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6-21-81</b>	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-16-1900</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
10. CITY OR TOWN OF DEATH <b>Yanston</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holly Hill Manor Nursing Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Parkville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Korn</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Graswick</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Telephone Operator</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-30-1369</b>		17. INFORMANT ADDRESS <b>Charles Freeman 9528 Bauer Avenue</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>46/19</b> <b>81</b> <b>Oct.</b> <b>19</b> <b>80</b> to <b>6-21</b> <b>19</b> <b>81</b> , that (I) (we) lost saw the deceased alive on <b>46/19</b> <b>19</b> <b>81</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen Laiken</b> DEGREE				22c. DATE SIGNED <b>6/22/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen LAIKEN</b>				22e. ADDRESS <b>6805 YORK Rd. 21212</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>		25a. DATE REC'D BY REGISTRAR <b>JUN 25 1981</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 1 4 7 1 2  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST <i>Edward Dallas Hearn</i>		MONTH DAY YEAR <i>June 10, 1981</i>	
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>	
5. DATE OF BIRTH MONTH DAY YEAR <i>June 20, 1918</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>62</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, MD.</i>	
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>6003 Windsor Mill Rd.</i>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Customs Inspector</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Treasury Dept.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>	
13c. CITY OR TOWN <i>Woodlawn</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <i>6003 Windsor Mill Rd.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Dallas Holland Hearn</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lula Patrick</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>W.W. II 215-07-1161</i>	
17. INFORMANT <i>Kenneth S. Hearn</i>		ADDRESS <i>716 Shore Dr. Joppa, Md. 21085</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes mellitus, County arteritis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>April</i> , 19 <i>70</i> , to <i>June 10</i> , 19 <i>81</i> , that (we) lost saw the deceased alive on <i>June 9</i> , 19 <i>81</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Herman Brecker</i>		22c. DATE SIGNED <i>6/11/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Herman Brecker</i>		22e. ADDRESS <i>6410 Windsor Mill Rd. Baltimore, MD 21207</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-13-81</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, Maryland 21133</i>		25a. DATE REC'D BY REGISTRAR <i>JUN 12 1981</i>	
25b. REGISTRAR'S SIGNATURE <i>Dorothy McBratney</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 172 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

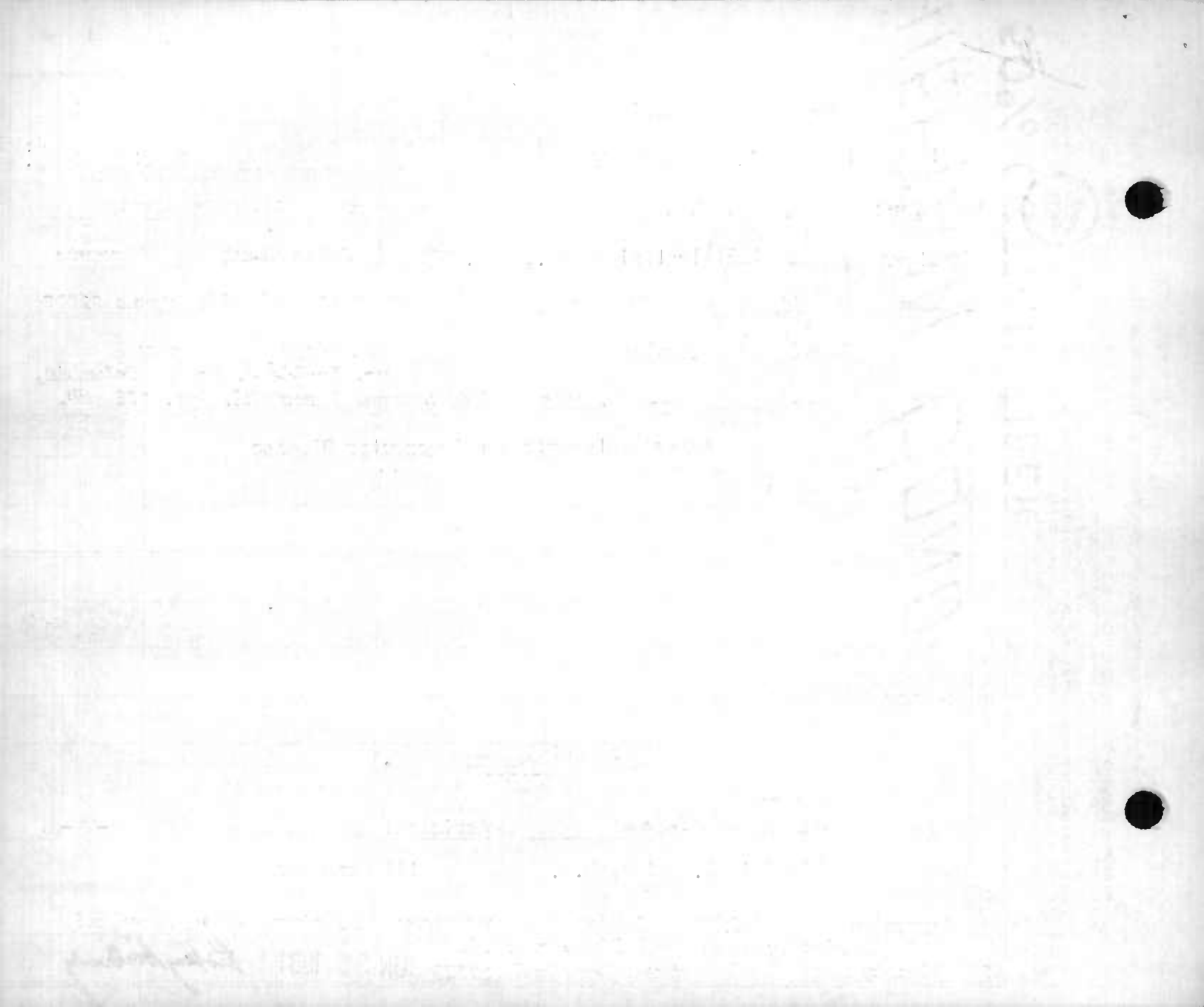
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Grace Marie Henry			2a. DATE KNOWN OF DEATH ESTIMATED XX 6 20 19 81			2b. HOUR M		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1926	6. AGE (IN YEARS (LAST BIRTHDAY)) 55 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 6 21 19 81	2d. HOUR 4:15 P. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Woodlawn		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1631 Ingleside Ave., Apt. 32			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Stewarts	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Balto County	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 1631 Ingleside Avenue 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Leslie Snyder				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Genevieve Brew				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Mrs. Leslie V. Henry Columbia, 5640 Stevens Forest Rd. Apt. 238 MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? (head only) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Virginia L. Dolan		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 6-22-81		
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 6/25/81		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland		
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, Maryland 21133				25a. DATE REC'D. BY REGISTRAR JUN 23 1981		25b. REGISTRAR'S SIGNATURE Loring Byers		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		IF UNDER 1 YEAR IF UNDER 24 HRS	
ELIZABETH HENTZE		June 1, 1981		8:00a M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Fem.	Cau.	MONTH DAY YEAR	77 YRS.	Baltimore County MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Md.	U.S.A		Homemaker		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY			
Balto.	Franklin Square Hosp.				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Md.	-	Balto.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4205 Parkmont Ave.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	16b. SOCIAL SECURITY NO.			
Joseph Stumpf	Elizabeth Musser	216-46-1618			
17. INFORMANT	ADDRESS				
John Stumpf	4214 Powell Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Bacteremic Shock					
DUE TO, OR AS A CONSEQUENCE OF					
(b) Sepsis due to Severe Decubitus Ulcer-sacral region					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from May 30, 1981, to June 1, 1981, that (we) last saw the deceased alive on June 1, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Dr. Rothbaum	M.D.			6-1-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
Dr. Rothbaum	9000 Franklin Square Drive 21237				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	2-4-81	Parkwood Cem.	CITY OR TOWN COUNTY STATE		
			Balto. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS		JUN 2 1981		Petry, Melvody	
John C. Miller Inc. 6415 Belair Rd.					

March 27, 1961

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 1 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Walter W. HENTZSCHEL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 16, 1981</b>			2b. HOUR <b>6:55A M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 3, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Elec. Super.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>City of Balt</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>9009 Perring Park Rd.</b>	
14. FATHER'S NAME <b>Theodore Hentzschel</b>				15. MOTHER'S MAIDEN NAME <b>Alma Loebner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>213-10-7996</b>		17. INFORMANT <b>Marie Hentzschel</b>		17e. ADDRESS <b>Same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Lymphatic Leukemia</b> 2041 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>5/14</b> , 19 <b>81</b> , to <b>6/16</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6/16</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE <b>AH Ghiladi</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-16-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>AH GHILADI</b>						22e. ADDRESS <b>7600 OSLER Dr. Towson</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/16/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b> 3331 Brehms La.-Balto., Md. 21213						25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Received by Special Agent

At the City of New York  
on the 1st day of June 1908  
I have received from the  
Postmaster General  
the sum of \$100.00  
for the use of the  
Post Office at New York  
City

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH										2b. HOUR					
DECEASED NAME (TYPE OR PRINT)		DATE KNOWN OF DEATH										HOUR					
FIRST MIDDLE LAST		MONTH DAY YEAR										M					
William Robert Hibbert		6 3 1981										12 30					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH					
MALE	White	MONTH DAY YEAR	LAST BIRTHDAY	MONTHS	DAYS	MONTH DAY YEAR	Baltimore Co					MD.					
1 27 31	50 YRS.	6 3 1981										12 30					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Maryland	U.S.A.		Franklin Square Hosp.					Apt 1 (Long)									
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY									
Bonville and 2137	Franklin Square Hosp.		Apt 1 (Long)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS													
Md	Baltimore	Baltimore	YES <input type="checkbox"/> NO <input type="checkbox"/>	1 Kerns Rd Et 2137													
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS				
FIRST MIDDLE LAST	FIRST MIDDLE LAST		Yes					1950-53					216-20-7936				
Lewis W. Hibbert	Eva A. McGlothlin												Eva A. Hall, Havre de Grace, Maryland.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a)																	
4100 Atherosclerotic Cardio Vascular Disease																	
DUE TO, OR AS A CONSEQUENCE OF																	
(Superior Myocardial Infarction)												2+ days					
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
None Known																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
John C. Hyle				Dpty				6-3-81									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
JOHN C. Hyle				7527 Belair Rd Baltimore, Md													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Cremation				June 5, 1981		Loudon Park Crematory				Baltimore, Baltimore, Maryland							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
Lee A. Patterson & Son, Perryville, Maryland.				JUN 15 1981				[Signature]									

waitman

See H. Patterson & John Forehand.

Latino, Latino, Latino

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH THE VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

Items #18a-22a Film G557 7/23/81r STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14717			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARVIS june HICKEY</b>										2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6-15-81		2b. HOUR 19 PM	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 21, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>57 YRS.</b>		7c. DATE PRONOUNCED DEAD <b>6-15-81</b>		7d. HOUR 19 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b>				10. CITY OR TOWN OF DEATH <b>Woodlawn</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>8630 Wright Mills Rd.</b>					
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>checker</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Giant Food</b>				13a. STREET ADDRESS <b>8630 Wrights Mill Road</b>					
13b. STATE <b>Maryland</b>				13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Gibis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virgie Moore</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>					
16b. SOCIAL SECURITY NO. <b>?</b>				17. INFORMANT <b>George W. Hickey Woodlawn, Md. 21207</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8880 IMMEDIATE CAUSE (a) Fracture of skull</b> Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) _____ (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>6 / 15 / 19 81</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>Subject fell</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8630 Wright Mills Rd. Baltimore Co., Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Margie DeWitt</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>6-16-81</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>					
23b. DATE <b>6/18/81</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge, Howard, Maryland</b>					
24. FUNERAL DIRECTOR <b>SLACK Funeral Home, Ellicott City, Maryland 21043</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Robert A. Kelly</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

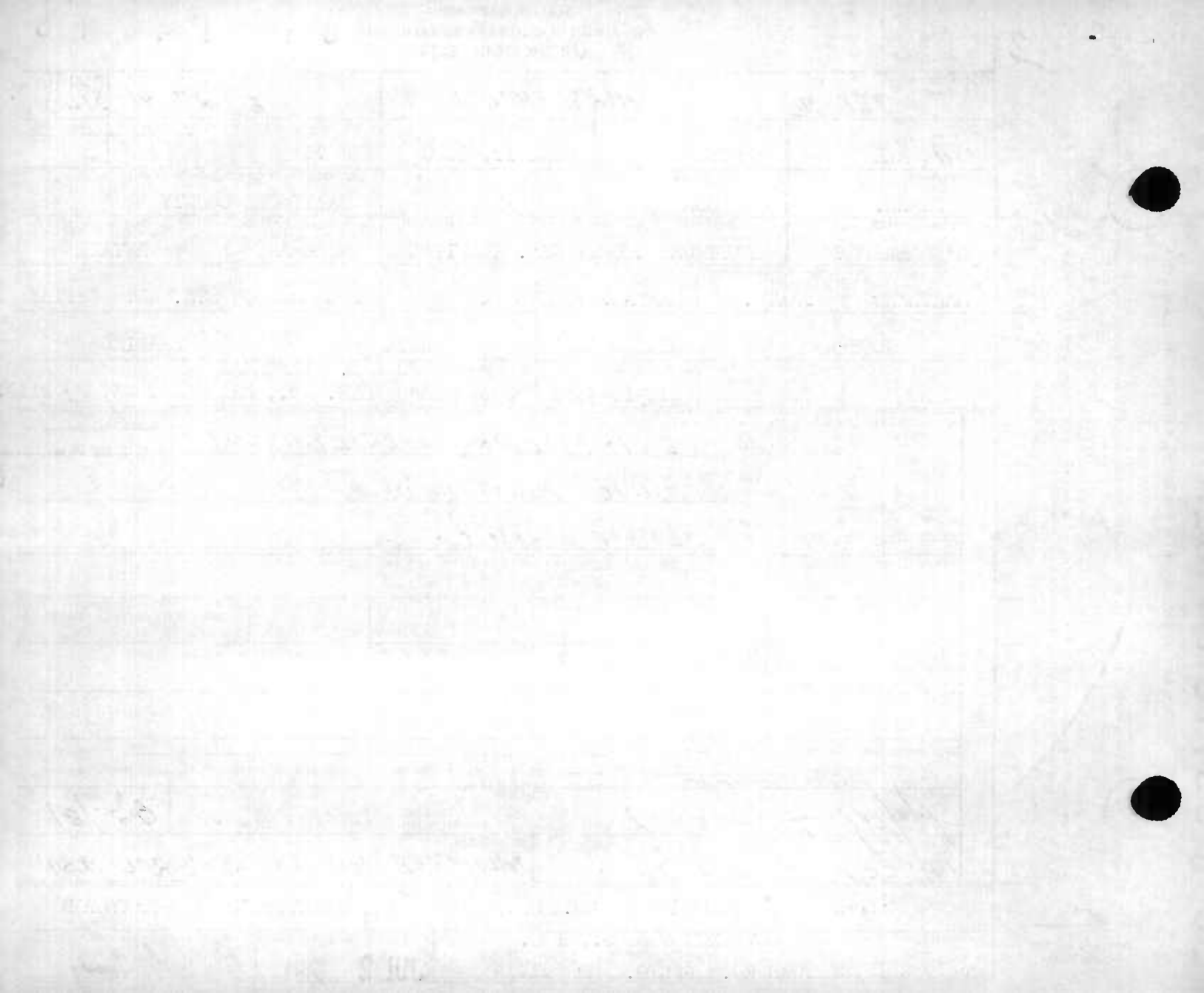
BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 1 8	
FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JEROME HIRSCHMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 27 81</b>		2b. <b>9940</b> P. <b>2140</b> M.
3. SEX <b>M ALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 12, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GEN. HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTO.</b>	13c. CITY OR TOWN <b>RANDALLSTOWN</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH HIRSCHMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTA SHAPIRO</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-16-4592</b>		17. INFORMANT <b>JOEL B. HIRSCHMAN</b> <b>9060 MEADOW HTS. RD., RANDALLSTOWN, MD 21133</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5184 VENTRICULAR FIBRILLATION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE PULM OEDEMA.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEPTIC SHOCK.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Hafeez A Syed</i>		DEGREE		22c. DATE SIGNED <b>6/27/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAFAEEZ A SYED M.D.</b>		22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSP</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/29/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CHIZUK AMUNO</b>		23d. LOCATION <b>BALTIMORE</b> COUNTY <b>MARYLAND</b> STATE
24. FUNERAL DIRECTOR NAME ADDRESS <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>			25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1981</b>		
			25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>		

MEDICAL CERTIFICATION

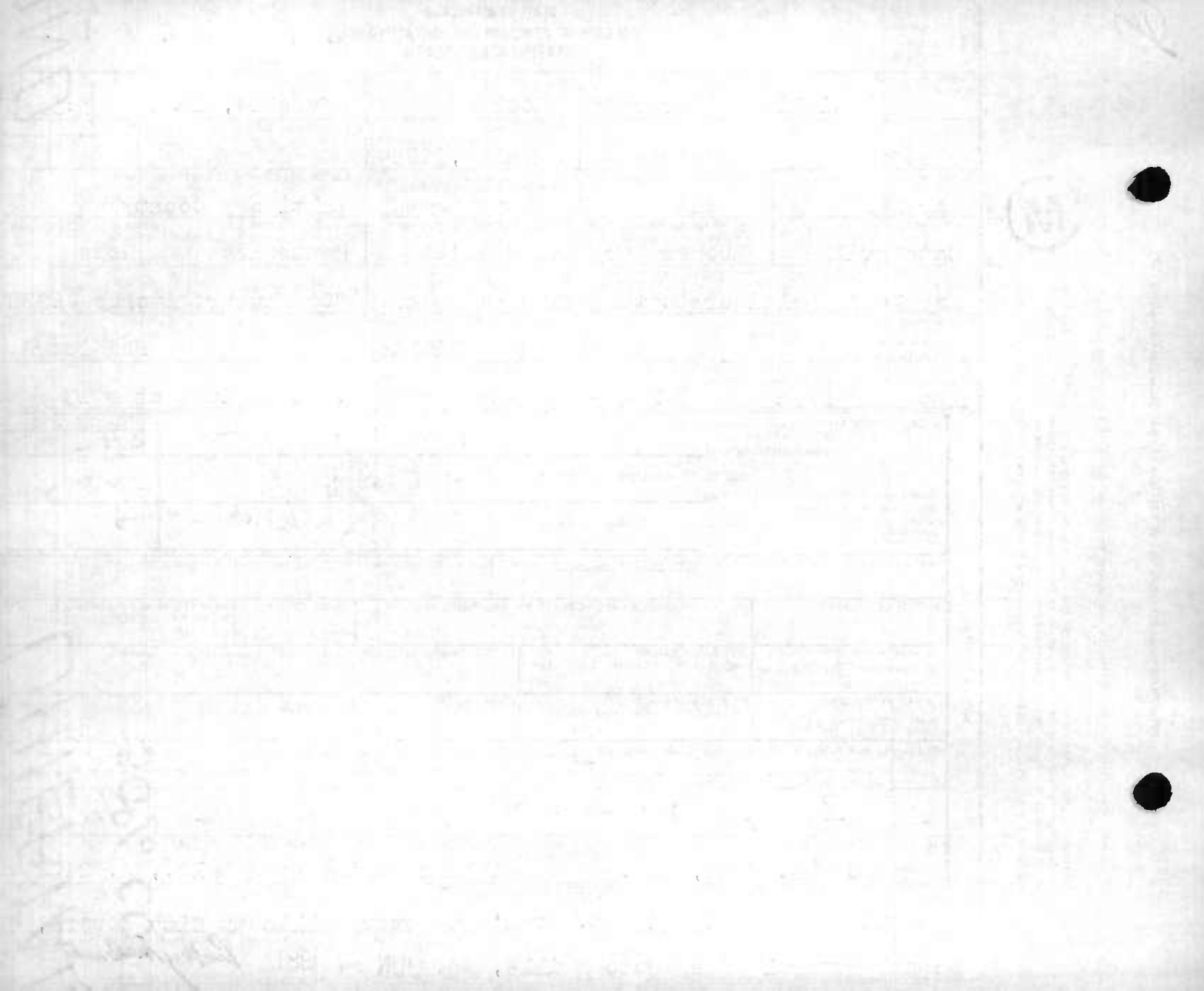




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian Gertrude Hook			2a. DATE OF DEATH MONTH DAY YEAR June 14, 1981				2b. HOUR AM M 5:55		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 27, 1894		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 Newburg Avenue 21228				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 306 Newburg Avenue 21228	
14. FATHER'S NAME FIRST MIDDLE LAST William Coates				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Peddicord					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Miss Helen M. Hook Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart, Fibrillation</u> 4148 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCAVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Old Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24h 20h									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (he/she) attended the deceased from 19 <u>72</u> to 19 <u>81</u> , that (he/she) saw the deceased alive on <u>3</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Raymond D. Bahr</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8/16/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Raymond D. Bahr, M.D.				22e. ADDRESS Wilkins & Pine Hgts Balt., Md. 21229					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/17/81		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery Ellicott City Howard, Md		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home				ADDRESS Catonsville, Md.		25a. DATE REC'D. BY REGISTRAR JUN 17 1981		25b. REGISTRAR'S SIGNATURE <u>Richard M. Bahr</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 2 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Beatrice Hopkins</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 20, 1981</b>			2b. HOUR M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sep. 11, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1001 W. Joppa Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nun</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Religious</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1001 W. Joppa Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Patrick Hopkins</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Druddy</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>---</b>		17. INFORMANT ADDRESS <b>1001 W. Joppa Rd. Mission Helpers of the Sacred Heart</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>&gt;10 yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Brain Syndrome</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>12/19</b> 19 <b>76</b> , to <b>6/20</b> 19 <b>81</b> , that (1) (we) just saw the deceased alive on <b>5/28</b> 19 <b>81</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (1) (we) ( <del>we</del> ) (and not) view the body after death.									
22b. SIGNATURE <b>Richard Maffezzoli</b>		DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>6/29/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard Maffezzoli, M. D.</b>				22e. ADDRESS <b>1205 York Road</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/22/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Convent Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Towson, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. E. Lowell Lemmon</b>				ADDRESS <b>10 W. Padonia Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 02 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

CVA

ADVIS

Change - 2000 - 2000

10/10/10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

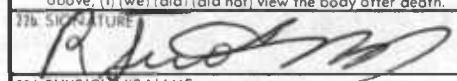

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARGARET Elaine HOPKINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 13 81</b>			2b. HOUR <b>6:45A</b> M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 23, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Baltimore Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clerical</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>615 Chestnut Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John T. Hopkins</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances G. Pollard</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>212-01-7222</b>		17. INFORMANT ADDRESS <b>Pickersgill Towson, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 4850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Carcinomatosis</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>6/13</b> , 19 <b>81</b> , to <b>6/13</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on _____, 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-13-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald L. Sirota, M.D.</b>						22e. ADDRESS <b>6701 N. Charles St. Towson, MD 21204</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 15, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>		25b. REGISTRAR'S SIGNATURE 		

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TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR - STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
HELEN P. HOUSMAN		June 18, 1981		5:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Female	White	Dec. 17, 1887	93 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	USA		Baltimore County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Towson	Holly Hill Nursing Home		Homemaker		Own Home
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS	
Maryland		Balto	Baltimore	704 Overbrook Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS	
John L. Potteiger		? Sherman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		193 12 9233		Mrs. Ann Jacobs Towson, Md.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Long standing Cardiac disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>Oct.</u> 19 <u>80</u> to <u>June 18</u> 19 <u>81</u> , that (I) we lost saw the deceased alive on <u>June 18</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Dr. Stephen Laiken</u> DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/19/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dr. Stephen Laiken, M.D.		6805 York Road, Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		6/22/81		Paxtang Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
Henry W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212		JUN 22 1981	
				25b. REGISTRAR'S SIGNATURE <u>Patricia...</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 2 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
THOMAS F. HRONOWSKI			June 19, 1981			3:30a M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	8 MONTH 4 DAY 1928	52 YRS.			IF UNDER 24 HRS		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			9. BALTIMORE CITY OR COUNTY OF DEATH			10. IF UNDER 24 HRS		
Maryland			Baltimore County			HOURS MIN.		
11. CITY OR TOWN OF DEATH			12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			13. BALTIMORE CITY OR COUNTY OF DEATH		
Rossville			Franklin Square Hospital			MD.		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. INSIDE CITY LIMITS?			16. STREET ADDRESS		
17a. STATE			17b. CITY OR TOWN			17c. STREET ADDRESS		
Maryland			Baltimore			7610 Meadow Way		
18. FATHER'S NAME			19. MOTHER'S MAIDEN NAME			20. BALTIMORE CITY OR COUNTY OF DEATH		
John Chronowski			Caroline Dembowczyk			MD.		
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			21b. SOCIAL SECURITY NO.			21c. INFORMANT		
Yes			Korea			Margaret S. Hronowski		
22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			24. BALTIMORE CITY OR COUNTY OF DEATH		
PART I. DEATH WAS CAUSED BY:			1519			25. BALTIMORE CITY OR COUNTY OF DEATH		
IMMEDIATE CAUSE (a)			Cardiopulmonary Arrest			26. BALTIMORE CITY OR COUNTY OF DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF			27. BALTIMORE CITY OR COUNTY OF DEATH		
			Carcinoma of Stomach			28. BALTIMORE CITY OR COUNTY OF DEATH		
			DUE TO, OR AS A CONSEQUENCE OF			29. BALTIMORE CITY OR COUNTY OF DEATH		
			(c)			30. BALTIMORE CITY OR COUNTY OF DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
31a. DATE OF OPERATION			31b. CONDITION FOR WHICH OPERATION WAS PERFORMED			31c. AUTOPSY?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
32a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			32b. TIME OF INJURY			32c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
			HOUR A.M. MONTH DAY YEAR					
			P.M. 19					
33a. INJURY OCCURRED			33b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33c. LOCATION		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						CITY OR TOWN COUNTY STATE		
34a. I certify that (this hospital) attended the deceased from May 23, 19 81, to June 19, 19 81, that (we) last saw the deceased alive on June 19, 19 81, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.			34b. SIGNATURE			34c. DATE SIGNED		
			DEGREE			6-19-81		
35a. PHYSICIAN'S NAME (TYPE OR PRINT)			35b. ADDRESS			35c. DATE REC'D. BY REGISTRAR		
Myo Thant			9101 Franklin Square Drive 21237			JUN 23 1981		
36a. BURIAL, CREMATION, REMOVAL (SPECIFY)			36b. DATE			36c. NAME OF CEMETERY OR CREMATORY		
Burial			6/21/1981			St. John's Slovak Summit Hill		
37a. FUNERAL DIRECTOR NAME			37b. ADDRESS			37c. REGISTRAR SIGNATURE		
Duda-Ruck, Inc.			7922 Wise Avenue Dundalk, MD. 21222			Pa.		



UNDER

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TOP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

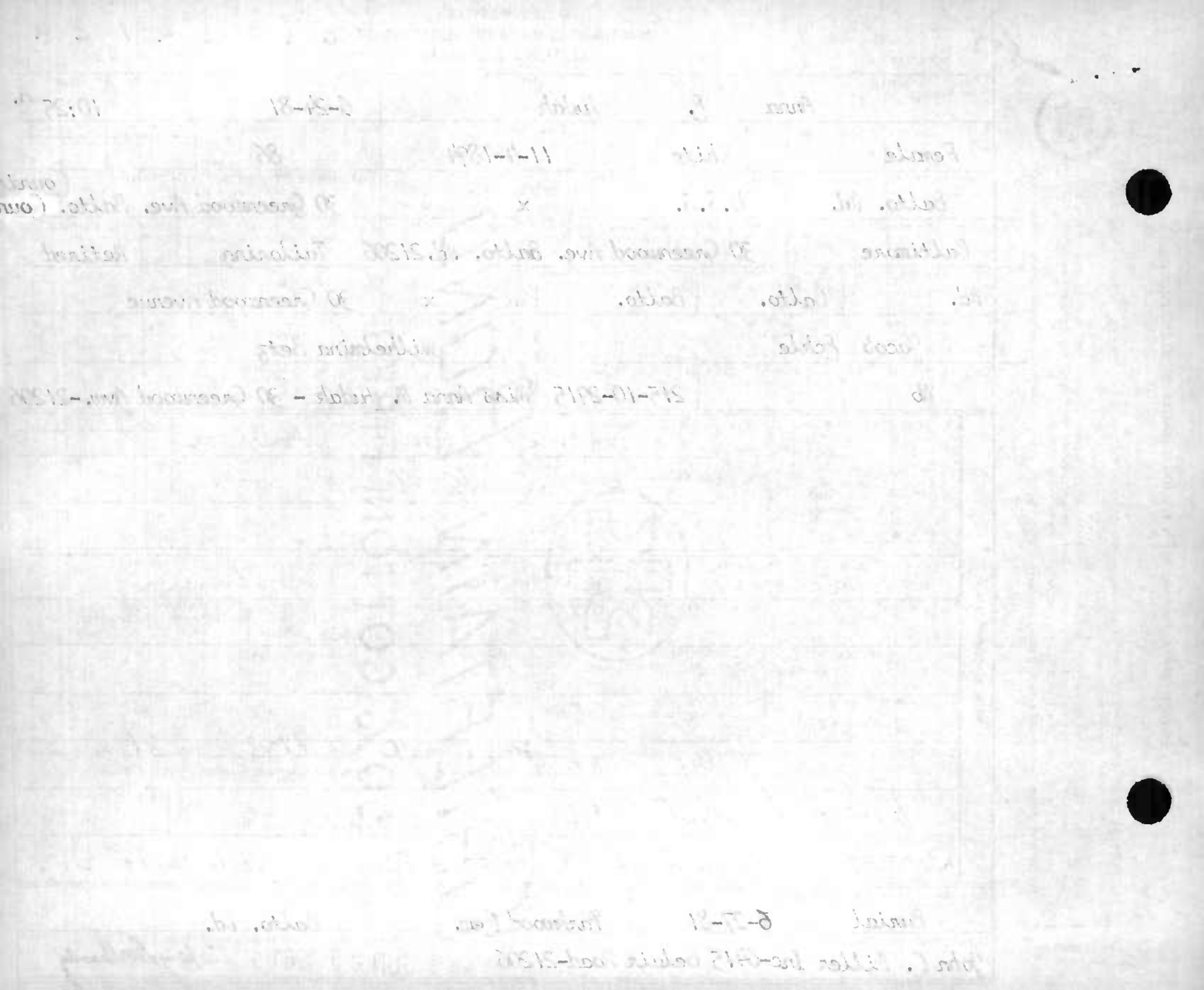
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna E. Hudak</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>6-24-81</i>			2b. HOUR MIN. <i>10:25 A.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-4-1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>86</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>30 Greenwood Ave. Balto.</i>			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>30 Greenwood Ave. Balto. Md. 21206</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Tailoring</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
13a. STATE <i>Md.</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS <i>30 Greenwood Avenue</i>									
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jacob Eckle</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Wilhelmina Bettz</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-10-2915</i>		17. INFORMANT ADDRESS <i>Miss Anna M. Hudak - 30 Greenwood Ave. - 21206</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>congestive heart failure</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart dis.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>2em Kew's diverticulum of esophagus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1981</i> to <i>6/24 1981</i> , that (I) (we) last saw the deceased alive on <i>6/24 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert Humbert M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ROBERT ROUBENOFF, M.D.</i>				22e. ADDRESS <i>7652 A Belair Road Balt. 2126.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>6-27-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. Md.</i>			
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc-6415 Belair Road-21206</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 29 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>			

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MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					8 1 1 4 7 2 5 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>DAVID Marshall HURD, JR.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-1-81</b>					2b. HOUR <b>12<sup>07</sup> PM</b>
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 03 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>IF UNDER 2 HRS. HOURS MIN.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD				
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unemployed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Marshall Hurd, Sr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Johnson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>008-20-3225</b>		17. INFORMANT ADDRESS <b>CL W. Johnson Hurd 6512 Alta Avenue</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease with heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pulmonary obstructive disease chronic</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>5-30-1981</b> to <b>6-1-1981</b> , that (I) (we) last saw the deceased alive on <b>6-1-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Soonchul Hong</b>					DEGREE			22c. DATE SIGNED <b>6-1-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SOON CHUL HONG</b>					22e. ADDRESS <b>Baltimore County General Hosp.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/10/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillside Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Castleton, Bennington, Vt.</b>				
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>					25. ADDRESS <b>7401 Belair Road</b>					





State

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Washington

U. S. Department of Justice

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Washington

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U. S. Department of Justice

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 7 2 6	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
George Washington Hutson				6 21 81				10:27pm			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS	
Male		White		12 19 1904		76		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Saint Josephs Hospital						Truck Driver-Weber Moving			
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9422 Ridgeley Avenue 21234			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Edward T Hutson				Katherine F Kappler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				216-01-7510		Catherine J. Hutson 9422 Ridgeley Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardio pulmonary arrest											
4960 DUE TO, OR AS A CONSEQUENCE OF											
(b) ASCVD											
DUE TO, OR AS A CONSEQUENCE OF											
(c) COPD											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 6-21 19 81, to 6-21 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 6-21 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
27b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		27c. DATE SIGNED	
Asif Inam										6/21/81	
27d. PHYSICIAN'S NAME (TYPE OR PRINT)				27e. ADDRESS							
ASIF INAM				ST. JOSEPH HOSPITAL, BALTO							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Cremation				6/23/81		Westview Crematory		CITY OR TOWN COUNTY STATE Westview Baltimore Md.			
24. FUNERAL DIRECTOR						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Sassaby H 7401 Belair Rd.						JUN 24 1981					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 2 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	HOUR
ETTA MARIE JACKSON				June 3rd 1981	7 P. M.
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		WHITE		MONTH DAY YEAR	
				89 (89) YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
MARYLAND		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		365 MITCHELL ROAD		BALTIMORE COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
BALTIMORE		365 MITCHELL ROAD		Mfg. Employee	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
U.S. Govt.		365 Mitchell Road.		BALTIMORE	
13c. STATE		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		365 Mitchell Road.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Albert LEAGUE		Sally MAGNESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT (Name and Address)	
NO		220-20-7074		Miss. Nancy L. Jackson 365 Mitchell Road Baltimore, Maryland 21221	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					20"
IMMEDIATE CAUSE (a) <u>Acute MYOCARDIAL INFARCTION</u>					
DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY HEART DISEASE</u>					years.
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/16/1980</u> to <u>6/3/1981</u> , that (I) (we) last saw the deceased alive on <u>6/3/1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>W. John</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/3/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
KHN M. TUN		2110 POT SPRING ROAD MD 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		JUNE 6, 1981		Fork Christian Church Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Fork, Baltimore Co., Maryland		JUN 9 1981			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014		JUN 9 1981		<u>Ray Hebert</u>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE JUDICIAL CLERK. GIVE PAGES 4 AND 5 TO THE MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGES 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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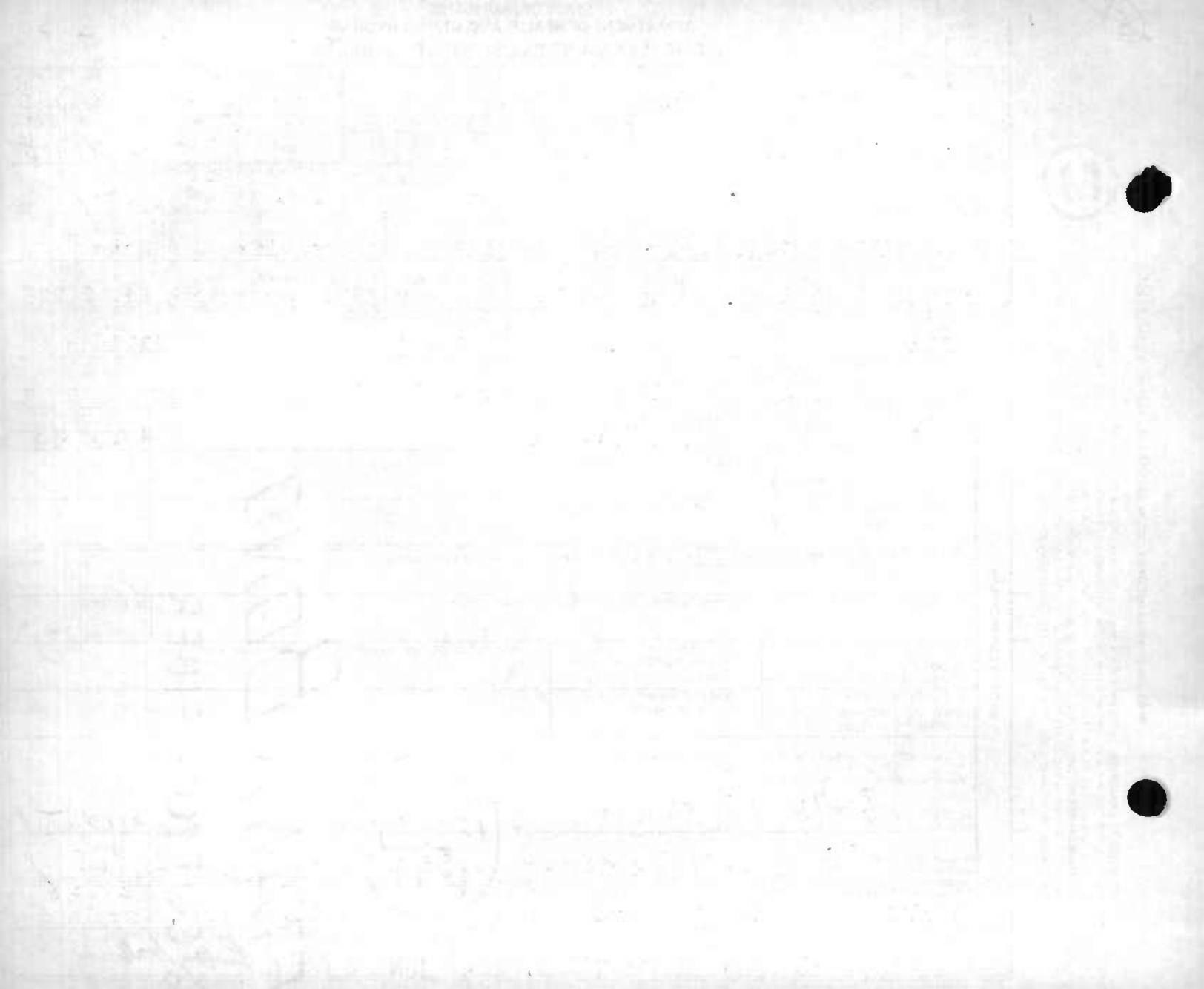
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madlana Mary James			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 6 12 1981		2b. HOUR 10:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 11/29/94	6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 12 1981
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Catonsville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1031 Marksworth Road 21228		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville	
14. FATHER'S NAME FIRST MIDDLE LAST William Stewart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Almedia Williams		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V.D.</u> 4292 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost.</u> (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE P. P. Williamson II		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 6/12/81	
EXAMINER'S NAME (TYPE OR PRINT) E. P. Williamson II		ADDRESS 5550 BALTO NAT'L PKWY			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/16/81		23c. NAME OF CEMETERY OR CREMATORY Loudon Park	
24. FUNERAL DIRECTOR NAME MacNabb Funeral Home		ADDRESS Catonsville, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
25a. DATE REC'D. BY REGISTRAR JUN 17 1981		25b. REGISTRAR'S SIGNATURE [Signature]			





Item 7a g557 7/7/81 gj

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

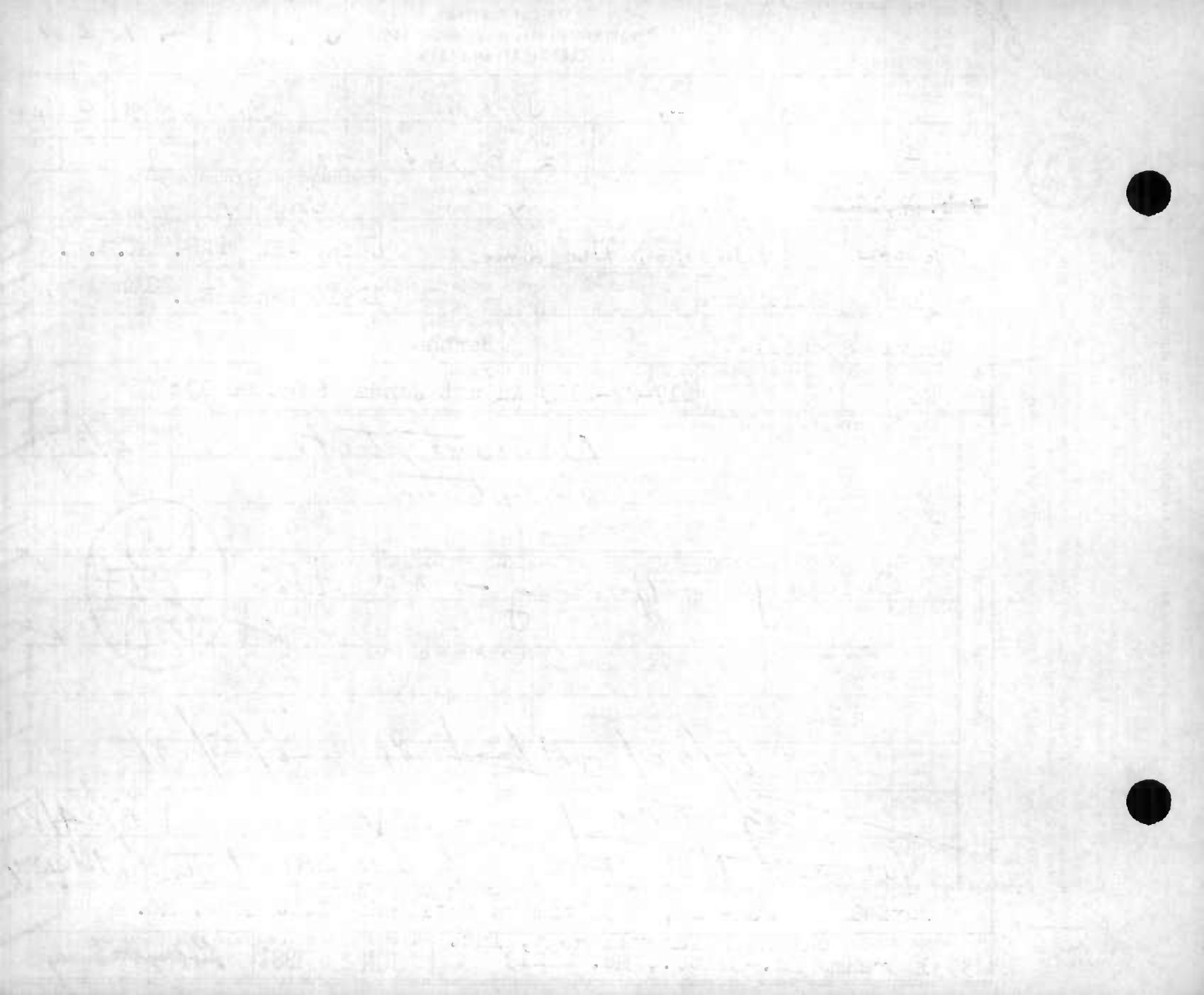
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>HELEN R. JANDA</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>JUNE 23 1981</i>			2b. HOUR <i>4:30 PM</i>	
3. SEX <i>7</i>		4. RACE <i>Cauc.</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 7 1904</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <i>77</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Feb. 7, 1904</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>County BALTO MD.</i>	
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Valley View Nsg. Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cafeteria Wrkr.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>A.R.A.</i>	
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Glen Arm, Md</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Conrad Sponsal</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Bertha</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>217-22-8113</i>		17. INFORMANT ADDRESS <i>August Janda Same as 13e</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <i>2765</i> IMMEDIATE CAUSE (a) <i>Recurrent stroke</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Dehydration</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Coronary insufficiency - old stroke AT</i>							APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH <i>6/20/81</i>
19a. DATE OF OPERATION <i>6/22/81</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Coronary insufficiency</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>6/22/81</i>		21f. LOCATION (CITY OR TOWN) COUNTY STATE <i>6/23/81</i>			
22a. I certify that (I) (this hospital) attended the deceased from <i>6/22/81</i> to <i>6/23/81</i> , that (I) (we) lost saw the deceased alive on <i>6/22/81</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.							
22b. SIGNATURE <i>Vuong Nguyen</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>6/24/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>VUONG NGUYEN</i>				22e. ADDRESS <i>6 LINCOLN St. Towson Md 21204</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>June 26, 81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		23d. LOCATION <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Schimunek Funeral Home, Inc.</i>				25a. DATE REC'D. BY REGISTRAR <i>JUN 26 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Lisa McBrady</i>	
3331 Brehms La.-Balto., Md. 21213							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 537-1234.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

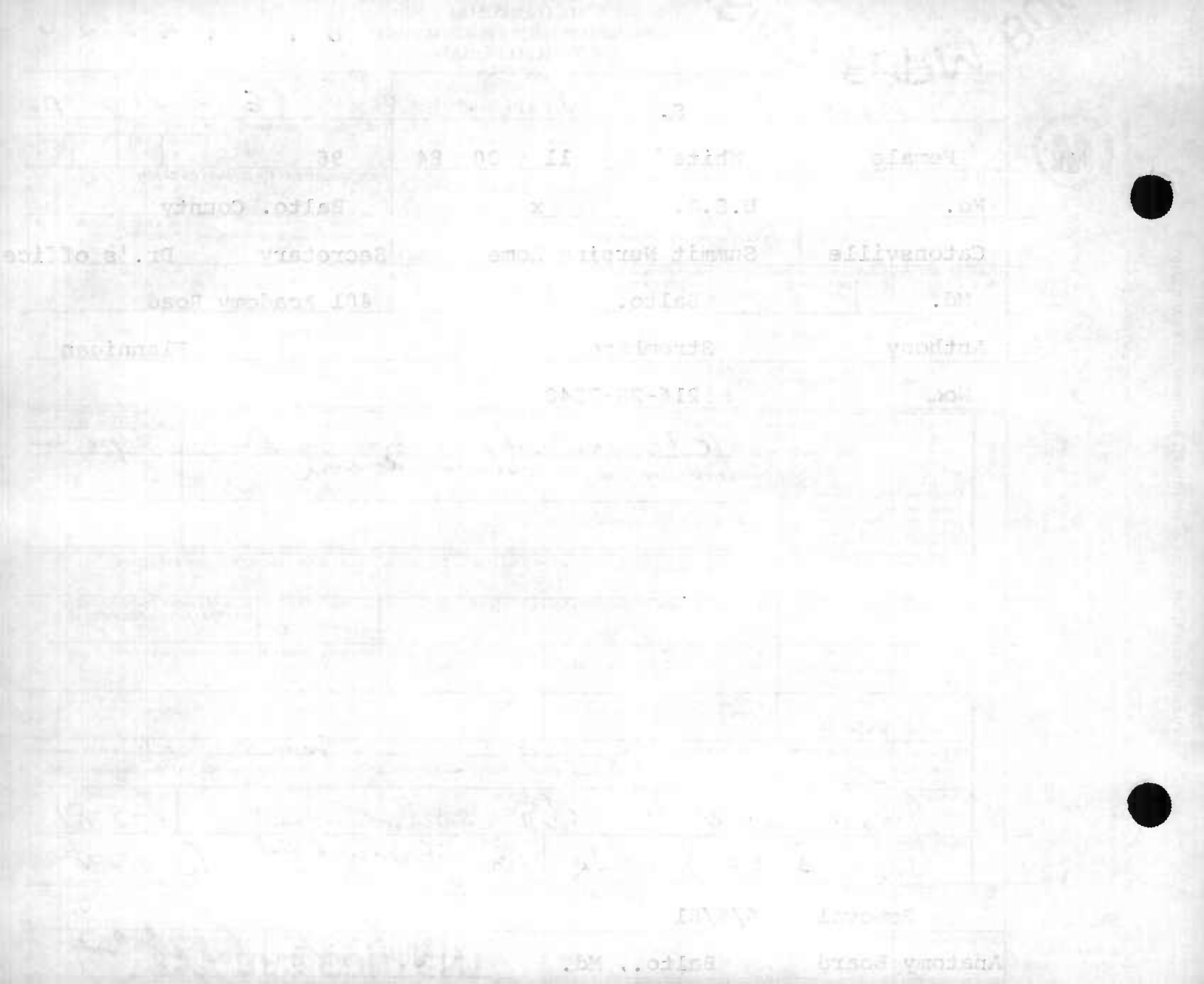
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a necropsy performed.1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 3 0

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MABEL S. JANNEY</b>			2a DATE OF DEATH MONTH <b>6</b> DAY <b>5</b> YEAR <b>81</b>			2b HOUR <b>0500 P.M.</b>					
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH <b>11</b> DAY <b>30</b> YEAR <b>84</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>96</b> YRS.		7 UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7 UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		9 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11 BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. County</b> MD.					
12 CITY OR TOWN OF DEATH <b>Catonsville</b>		13 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>				14 USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>			15 KIND OF BUSINESS OR INDUSTRY <b>Dr.'s office</b>		
16 USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b COUNTY <b>Balto.</b> 13c CITY OR TOWN <b>Balto.</b>				17 INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				18 STREET ADDRESS <b>401 Academy Road</b>			
19 FATHER'S NAME FIRST <b>Anthony</b> MIDDLE <b>Stromberg</b> LAST <b>Stromberg</b>				20 MOTHER'S MAIDEN NAME FIRST <b>Flannigan</b> MIDDLE <b>Flannigan</b> LAST <b>Flannigan</b>							
21 WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		22 SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-28-7548</b>		23 INFORMANT ADDRESS							
24 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Anterior wall myocardial infarction</b> <b>4370</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs +</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
25a DATE OF OPERATION			25b CONDITION FOR WHICH OPERATION WAS PERFORMED			26a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			26b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			27b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			27c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
28a INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			28b PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			28c LOCATION STREET CITY OR TOWN COUNTY STATE					
29 I certify that (I) (the hospital) attended the deceased from <b>1977</b> 19 <b>June 5</b> 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>5-27</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
29a SIGNATURE <b>John A. Mesbitt Jr.</b>						29b DEGREE <b>MD</b>			29c ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
29d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN A. MESBITT JR</b>						29e ADDRESS <b>1009 Frederick Rd Baltimore, Md. 21228</b>					
30 BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			31 DATE <b>6/5/81</b>			32 NAME OF CEMETERY OR CREMATORY			33 LOCATION CITY OR TOWN COUNTY STATE <b>BALTO.</b>		
34 FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						35 ADDRESS <b>Balto., Md.</b>			36 DATE REC'D. BY REGISTRAR <b>JUN 15 1981</b>		
37 REGISTRAR'S SIGNATURE <b>John A. Mesbitt Jr.</b>											

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH: 16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 3 1

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY Elizabeth LAST JELKS		2a. DATE OF DEATH MONTH DAY YEAR 6 6 81 2b. HOUR 1:40 AM	
3. SEX FEMALE	4. RACE CAUC	5. DATE OF BIRTH MONTH DAY YEAR 7 18 09	
6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, COUNTY MD.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive Secretary		12b. KIND OF BUSINESS OR INDUSTRY Bank	
13a. STATE Maryland		13b. COUNTY Baltimore	
13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 202 Linden Terrace			
14. FATHER'S NAME FIRST MIDDLE LAST James A. Henry		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Roddy	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-14-8599	
17. INFORMANT Edward A. Jelks		ADDRESS Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <u>MARCH</u> , 19 <u>81</u> , to <u>JUNE 6</u> , 19 <u>81</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>MAY 23</u> , 19 <u>81</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.			
22b. SIGNATURE <u>Charles B. Hutton</u> MD		22c. DATE SIGNED 6/6/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES B. HUTTON M.D.		22e. ADDRESS 7100 OSLER DR. TOWSON, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 9, 1981	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc.		25a. ADDRESS 6500 York Rd. Balto., Md.	
25b. RECEIVED BY REGISTRAR JUN 10 1981		25c. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

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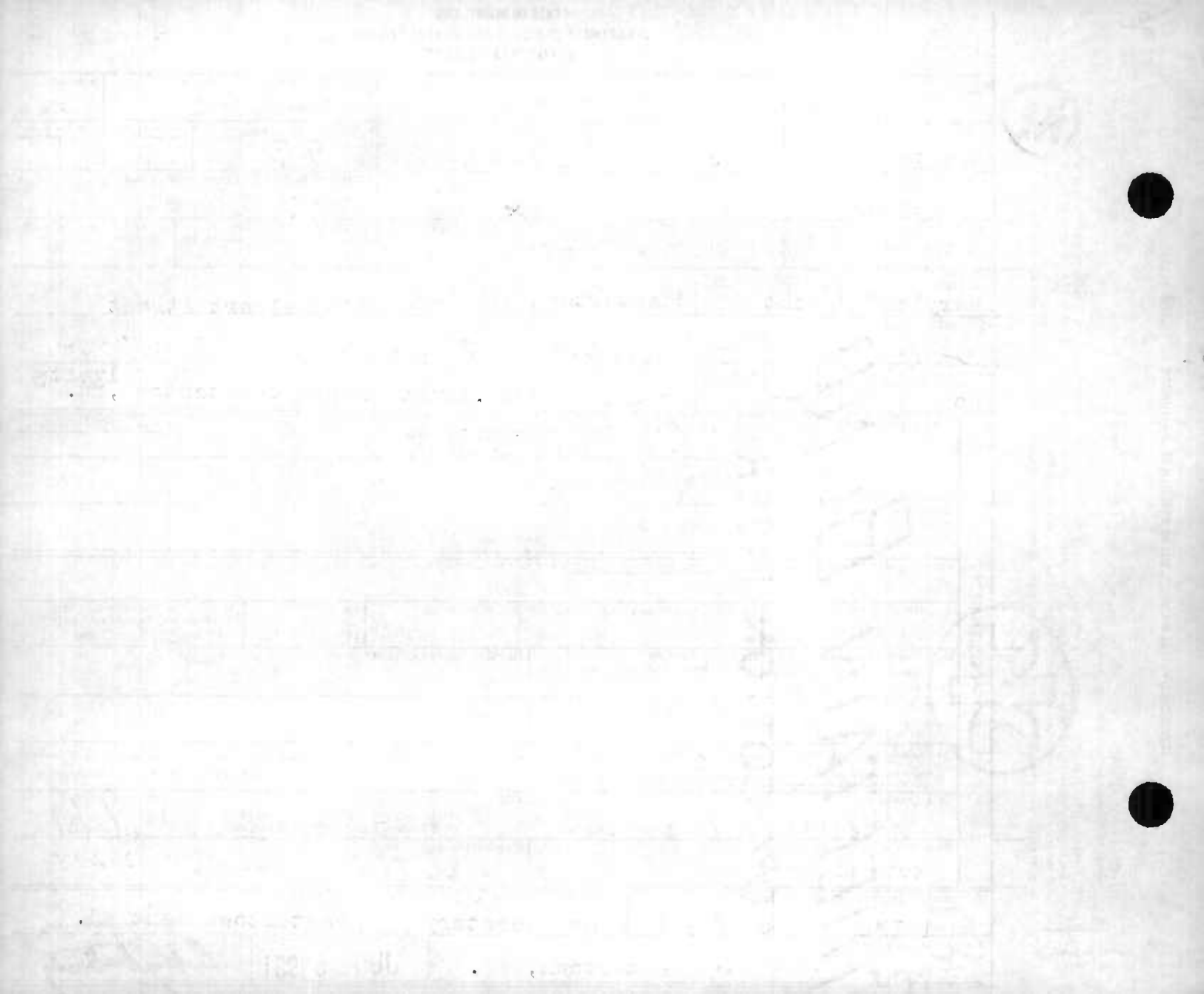
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 3 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Carrie B. Jennings				2a. DATE OF DEATH MONTH DAY YEAR June 2, 1981		2b. HOUR 8:00a M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR JUNE 29, 1987		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST E. J. A. H. STRICKLIN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabella Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. YES		17. INFORMANT Mrs. Irene Graham			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CVA (C.V.A.) (c) DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from May 31, 1981, to June 2, 1981, that (X) (we) last saw the deceased alive on June 2, 1981, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do not) view the body after death.							
22b. SIGNATURE Morton C. Orman				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morton C. Orman, M.D.				22e. ADDRESS 2936 E. BALTIMORE ST 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/6/1981		23c. NAME OF CEMETERY OR CREMATORY James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown Kent Md.	
24. FUNERAL DIRECTOR NAME B. Smith				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 15 1981	
				25b. REGISTRAR'S SIGNATURE R. J. Roberts			

BP





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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 3 3	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Dolores B. Johnson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 30, 1981</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 19, 1902</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Catonsville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James P. Monaghan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Regina Kraft</b>		12a. USUAL OCCUPATION (IF NOT WORKING) <b>Housewife &amp; Bookkeeper</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-03-6536</b>		17. INFORMANT ADDRESS <b>Catonsville, Md. 21228.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASH D</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> years				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Bronchectasis</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1976</b> to <b>6/30 1977</b> , that (I) (we) last saw the deceased alive on <b>6/24 1981</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>James Nolan</b>		DEGREE		22c. DATE SIGNED <b>7/1/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NOLAN J.</b>		22e. ADDRESS <b>1 Mallory Hill Ave Balt Md 21209</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery- Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Seidling Funeral Edith</b>		24b. ADDRESS <b>736 Edmondson Ave. Catonsville Md 21228</b>		25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1981</b>	
				REGISTRAR'S SIGNATURE <b>Robert McCready</b>	



*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]*

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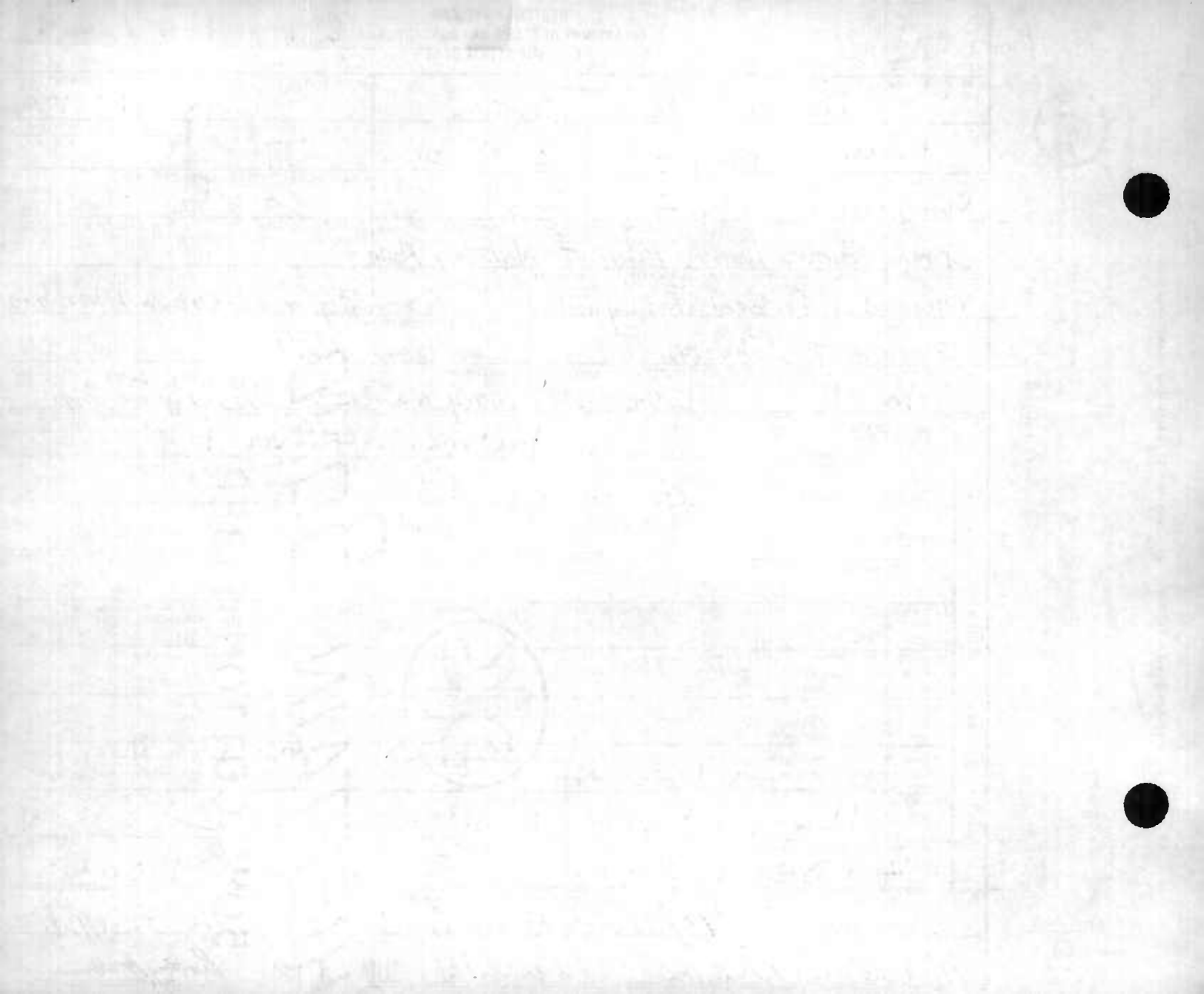
DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR 6-13-81		2b. HOUR 10A <sup>05</sup>	
1. DECEASED NAME (TYPE OR PRINT) Thomas H Johnson		3. SEX Male		4. RACE Negro	
5. DATE OF BIRTH 4-27-04		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. BALTIMORE CITY OR COUNTY OF DEATH County MD.	
11. CITY OR TOWN OF DEATH Spring Grove		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bryant Nursing Home		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
14. STATE Maryland		15. COUNTY Pr. Geo.		16. CITY OR TOWN Rosaryville	
17. FATHER'S NAME George T. Johnson		18. MOTHER'S MAIDEN NAME Caroline Hall		19. STREET ADDRESS Box 4105 - Upper Marlboro	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21. SOCIAL SECURITY NO. 717-07-6907		22. INFORMANT ADDRESS Mary H. Johnson Box 241 Brandywine Md.	
23. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio pulmonary arrest</u> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cancer of rectum with</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE	
33. I certify that (I) (this hospital) attended the deceased from <u>1-30-81</u> to <u>6-13-81</u> , that (I) (we) last saw the deceased alive on <u>6-13-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
34. SIGNATURE H. Devados		35. DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		36. DATE SIGNED 6-13-81	
37. PHYSICIAN'S NAME (TYPE OR PRINT) H. Devados		38. ADDRESS BOS Nursing Home.			
39. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		40. DATE 6/17/81		41. NAME OF CEMETERY OR CREMATORY Holy Resary Ch. Co Rosaryville	
42. FUNERAL DIRECTOR NAME Martell Adams		43. ADDRESS Crown Mt		44. DATE REC'D. BY REGISTRAR JUN 25 1981	
45. REGISTRAR'S SIGNATURE P. G. Gindi		46. REGISTRAR'S SIGNATURE P. G. Gindi			

0600 BP

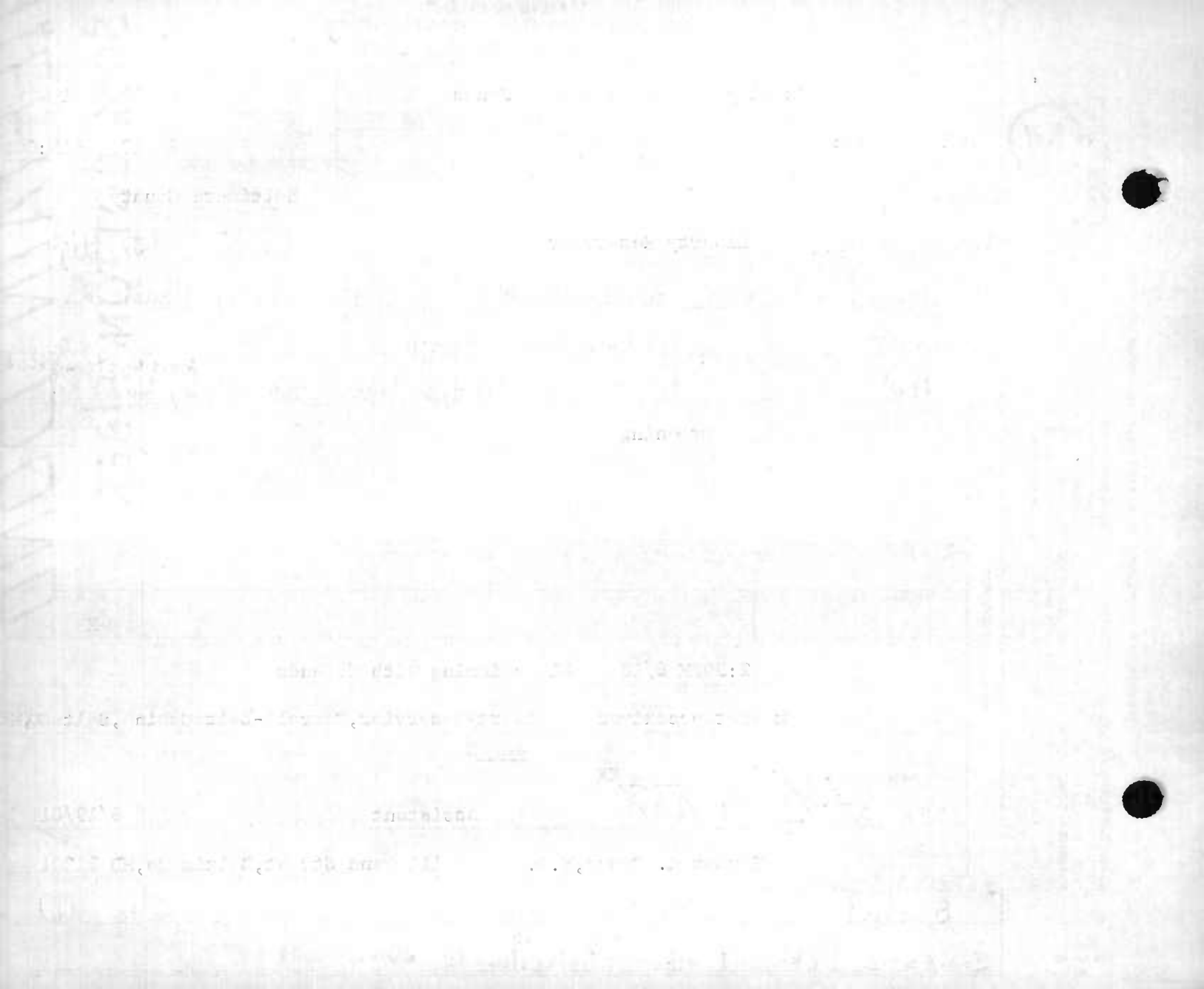


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14735	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) <b>Stanley Leandrew Jones</b>							2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>6</b> DAY <b>18</b> YEAR <b>1981</b>	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>25</b> YEAR <b>67</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>14</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>6</b> DAY <b>18</b> YEAR <b>1981</b>		2d. HOUR <b>00</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Liberty Reservoir</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Jr. High</b>			
13a. STATE <b>Maryland</b>			13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Reisterstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>486 Shirley Manor Rd.</b>		
14. FATHER'S NAME FIRST <b>Vincent</b> MIDDLE <b>Westmorlen</b> LAST <b>Betty</b>			15. MOTHER'S MAIDEN NAME FIRST <b>S.</b> MIDDLE <b>Jones</b> LAST <b>Jones</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					
16a. SOCIAL SECURITY NO. <b>-</b>			17. INFORMANT <b>Betty S. Jones</b>			ADDRESS <b>486 Shirley Manor Rd.</b>			17. INFORMANT ADDRESS <b>Reisterstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Drowning</b> IMMEDIATE CAUSE (a) <b>9102</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:30PM 6/18 1981</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>swimming with friends</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Patapsco River</b>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Liberty Reservoir, Carroll-Balto Co Line, Balto Co, Md.</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Accident</b> <input checked="" type="checkbox"/> Natural Causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>H. Guard</b>			TITLE (SPECIFY) <b>Assistant</b>			DATE SIGNED <b>6/19/81</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>			ADDRESS <b>111 Penn Street, Baltimore, MD 21201</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>June 22, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Glen Burnie Balto. Md.</b>				
24. FUNERAL DIRECTOR NAME <b>James B. Eckhardt</b>			ADDRESS <b>4605 Reisterstown Rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 20 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			





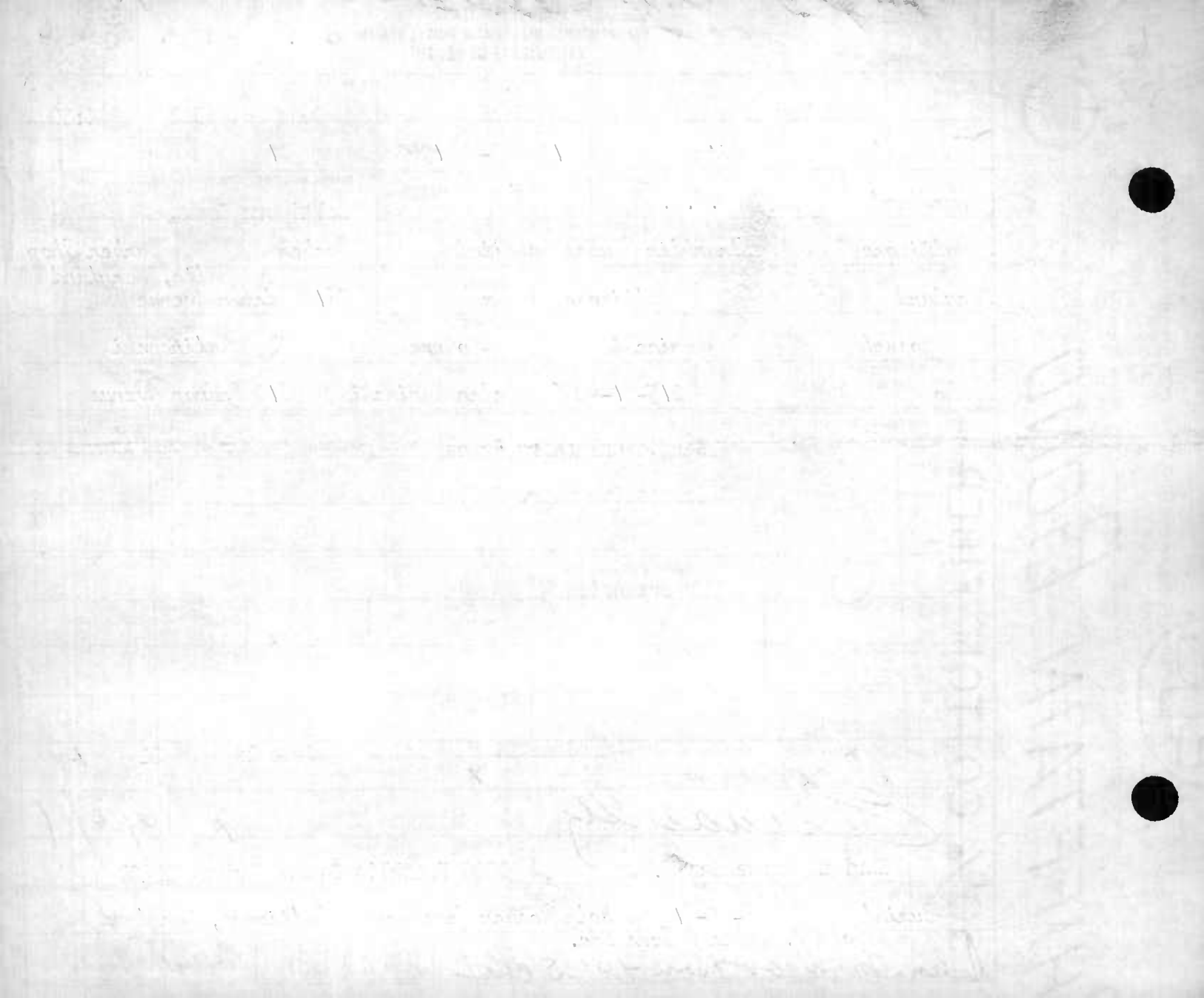
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Stanley KANIECKI</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 26, 1981</b>				
3. SEX <b>Male</b>					2b. HOUR <b>4:10</b> a				
4. RACE <b>White</b>					5. DATE OF BIRTH MONTH DAY YEAR <b>10 7- 1909</b>				
6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.					7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (COUNTRY) <b>Maryland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Baltimore</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>				
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>Barber Shop</b>				
13a. CITY OR TOWN <b>Baltimore</b>					13b. STREET ADDRESS <b>3610 Edman Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Kaniecki</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JoAnne Kalinowski</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>					16b. SOCIAL SECURITY NO. <b>215-01-4266</b>				
17. INFORMANT <b>Helen Kaniecki</b>					ADDRESS <b>3610 Edman Avenue</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary Arrest</b> <b>4280</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Hypertension</b>									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>June 24</b> , 19 <b>81</b> , to <b>June 26</b> , 19 <b>81</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>June 26</b> , 19 <b>81</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Enrique Hernandez M.D.</b>					22c. ADDRESS <b>9000 Franklin Square Drive 21237</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>6-29-81</b>				
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>				
24. FUNERAL DIRECTOR NAME <b>John M. Weber &amp; Sons Inc.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>				
25b. REGISTRAR'S SIGNATURE <b>L. J. McCready</b>									

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 7 3 7	
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Josephine Kant</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>June 18, 1981</b>				2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 19, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		IF UNDER 1 YEAR MONTHS DAYS YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Carney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2907 Scherer Ave</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Carney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2907 Scherer Ave</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Olszewski</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Tina Phillip</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-22-7838</b>		17. INFORMANT ADDRESS <b>Mrs. Lillian V. Ireland 2909 Scherer Ave.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>A-S.C.V.D.</b> several years. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-24-1951</b> to <b>6-18-1981</b> , that (I) (we) last saw the deceased alive on <b>6-1-1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. Ellsworth Cook</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6-18-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ellsworth Cook M.D.</b>				22e. ADDRESS <b>2431 Maryland Ave Baltimore, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>June 22, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>						25. DATE RECEIVED BY REGISTRAR <b>JUN 19 1981</b>		26. SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

BP



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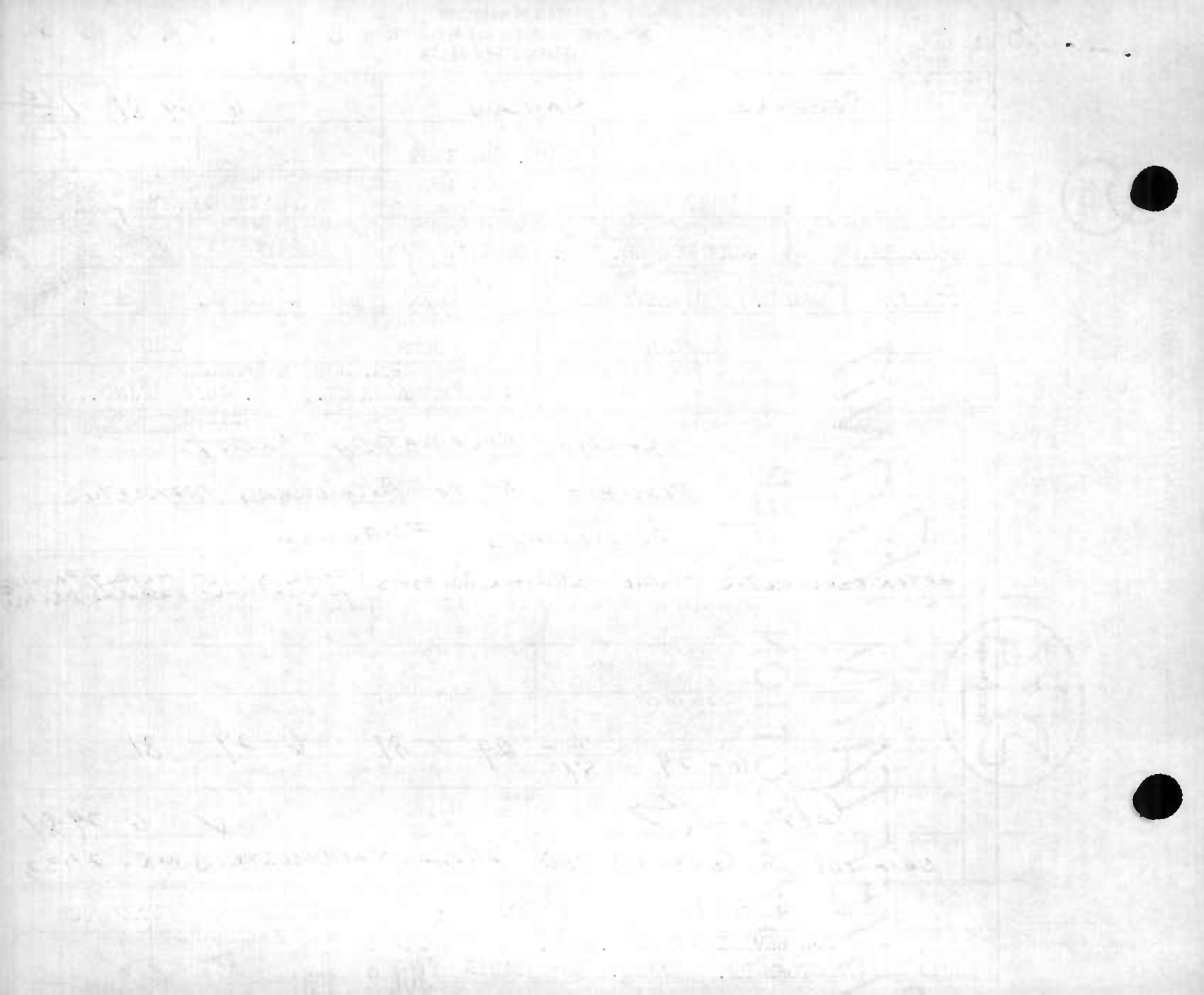
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA KAPLAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6-29-81</b>			2b. HOUR <b>1:10 PM</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 20, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>				
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE CO. GEN. HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>8314 LAGES LA. #21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH CAPLAN</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DORA KARP</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>NO</b>			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. JOLINE SANDLER</b> <b>4 CANDLEMAKER CT., APT. 403 BALTO., MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>POSSIBLE ACUTE PULMONARY INFARCTION</b> (c) <b>PULMONARY EMBOLISM</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>ARTERIOSELEPTIC CARDIOVASCULAR DISEASES; CONGESTIVE HEART FAILURE; PERIPHERAL VASCULAR DISEASE</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6-29-81</b> to <b>6-29-81</b> , that (I) (we) lost saw the deceased alive on <b>6-29-81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE 					DEGREE		22c. DATE SIGNED <b>6-29-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ORANOD B. CONANAN, MD</b>					22e. ADDRESS <b>BCH - RANDALLSTOWN MD. 21133</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH</b>		23d. LOCATION BALTIMORE COUNTY MARYLAND			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 2 1981</b>		25b. REGISTRAR'S SIGNATURE 			
6010 REISTERSTOWN RD. BALTO., MD 21215										

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
CERTIFICATE OF DEATH											
REG. NO.											
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES K. KELLEY</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 12, 1981</b>					2b. HOUR <b>10:25<sup>a</sup> M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1/13/07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>ROSSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQ.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY <b>AIRCRAFT</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>MIDDLE RIVER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1404 THIRD RD</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>HERBERT O. KELLEY</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVA C. SELL</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>UNK</b>			16b. SOCIAL SECURITY NO. <b>171 071087</b>		17. INFORMANT <b>HAZEL KELLEY</b>			ADDRESS <b>ABOVE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) METASTATIC CA, LUNG</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 11</b> , 19 <b>81</b> , to <b>June 12</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>June 12</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.											
22b. SIGNATURE <b>G. Stuart</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>6-12-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Stuart</b>						22e. ADDRESS <b>5400 Old Court Rd. Randallstowne, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6/17/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HOLLY HILL</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>J. G. CONNELLY</b>						ADDRESS <b>300 MACE</b>			25. DATE RECEIVED BY REGISTRAR <b>June 15 1981</b>		
						25a. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION





RECEIVED  
JAN 10 1941  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.



1941  
JAN 10 1941  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1941  
U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 7 4 0	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LOUCEL M. KERN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>06 16 81</b>		2b. HOUR <b>4 M</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 16 05</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>00 00</b>		7. IF UNDER 24 HRS. HOURS MIN. <b>00 00</b>	
7a. BIRTHPLACE COUNTRY <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b>			MD		
10. CITY OR TOWN OF DEATH <b>MIDDLE RIVER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>512 CRISFIELD ROAD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION -</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>MIDDLE RIVER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>512 CRISFIELD ROAD, 21220</b>		BALTO. CITY	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM MILLER</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA FORNEY</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>218-22-8615</b>		17. INFORMANT ADDRESS <b>JAMES G. KERN 512 CRISFIELD ROAD, 21220</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>Adenocarcinoma of colon with metastases</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/79</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>12:30 M. 6/15 19 81</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>did not</del> attended the deceased from <b>November 22, 19 77</b> , to <b>June 15, 19 81</b> , that (I) <del>XX</del> last saw the deceased alive on <b>June 1, 19 81</b> , and that in (my) (an) <del>XX</del> opinion death occurred on the date and hour and from the causes stated above. (If) <del>XX</del> did not view the body after death.											
22b. SIGNATURE <i>W. K. Gallager, Jr.</i> DEGREE								22c. DATE SIGNED <b>6/18/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILMER K. GALLAGER, JR., M.D.</b>								22e. ADDRESS <b>PINE HEIGHTS &amp; WILKENS AVENUES, 21229</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>06-19-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE CITY MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>						25a. DATE REC'D. BY REGISTRAR <b>JUN 18 1981</b>		25b. REGISTRAR'S SIGNATURE <i>Patricia M. Brady</i>			

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1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 7 4 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST OLIE EMMETT KIMBLE				2a. DATE OF DEATH MONTH DAY YEAR 6 7 81		2b. HOUR 0505 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Middle River		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16 Transverse Ave., 21220		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Ship Yard	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 16 Transverse Ave. 21220	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel A. Kimble				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hedrick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217 10 0282		17. INFORMANT ADDRESS Lona Malinda Kimble, wife Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jun 1</u> , 19 <u>73</u> , to <u>9-20</u> , 19 <u>80</u> , that (I) (we) lost saw the deceased alive on <u>9-20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If <del>not</del> (did not) view the body after death.							
22b. SIGNATURE Stuart H. Brager, M.D.				DEGREE M.D.		22c. DATE SIGNED 6-8-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart H. Brager, M.D.				22e. ADDRESS 302 Green Spring Station Baltimore, Md. 21093			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-10-81		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore County, Maryland	
24. FUNERAL DIRECTOR Brazdzinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR JUN 8 1981		25b. REGISTRAR'S SIGNATURE Rickey McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 4 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Maria E. KIRNOS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1981</b>			2b. HOUR <b>8:00A M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 15, 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1815 Coburg Court Apt A1</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>-- -- Baranski</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>-- --</b>			13e. STREET ADDRESS <b>1815 Coburg Court Apt A1</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT ADDRESS <b>Baltimore, Md.</b> <b>Halina J. Hugel 27 Belhaven Drive 21236</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-----</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19 81</b> , to <b>JUNE 22 1981</b> , that (I) (we) last saw the deceased alive on <b>JUNE 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Celiar E. Parra</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>June 22, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Celiar E. Parra, M.D.</b>			22e. ADDRESS <b>7122 Harford Road Baltimore, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 24, 81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrews Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Baltimore Co., Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Dipol Funeral Homes, Inc.</b>			ADDRESS <b>7110 Belair Road Baltimore, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 23 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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8:00A

June 22, 1981

ALBANY

W. E. Davis

MA

June 22, 1981

Vice

Board

Albany County

W. E. Davis

Albany

Albany County

W. E. Davis

Albany County

Albany

Albany County

Albany County

Albany

Albany

Albany, MA

Albany, MA

MA

June 22, 1981

MA

Albany County

Albany, MA

Albany County

Albany

Albany

Albany



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHM-17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14743	
1. DECEASED NAME (TYPE OR PRINT) <i>ALBERTA MARIE Klein</i>										20. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR <input checked="" type="checkbox"/> 6 5 1981	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>12</i> DAY <i>30</i> YEAR <i>04</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) <i>76</i> YRS.		IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i>	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Franklin Sq. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dietary Dept.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bon Secour Hospital</i>	
13a. STATE <i>Md.</i>				13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>8310 Karl Avenue 21237</i>	
14. FATHER'S NAME FIRST <i>James</i> MIDDLE <i>Robinson</i> LAST <i>Robinson</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Connelia</i> MIDDLE <i>Connelia</i> LAST <i>Connelia</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>218-30-6662</i>		17. INFORMANT <i>Mr. Robert A. Klein</i>				ADDRESS <i>21237 8310 Karl Avenue</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Atherosclerotic Cardiovascular Disease</i> <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <i>Diabetes Mellitus</i> (c) <i>Diabetes Mellitus</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unk</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Diabetes Mellitus</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John C. Hyle</i>				M.D. <i>John C. Hyle</i>				MEDICAL EXAMINER <i>John C. Hyle</i>		DATE SIGNED <i>6-5-81</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN C. HYLE</i>				ADDRESS <i>7527 Redmi Pl Baltimore 21236 Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>6-8-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME <i>John C. Miller Inc</i> ADDRESS <i>6415 Belair Rd. - 21206</i>						25a. DATE REC'D. BY REGISTRAR <i>JUN 9 - 1981</i>		25b. REGISTRAR'S SIGNATURE <i>John C. Hyle</i>			

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For more information, contact:

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Mr. Robert A. Klein - 8710 Ford Avenue

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer's death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Items 16b17 g557 7/7/81 g3

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

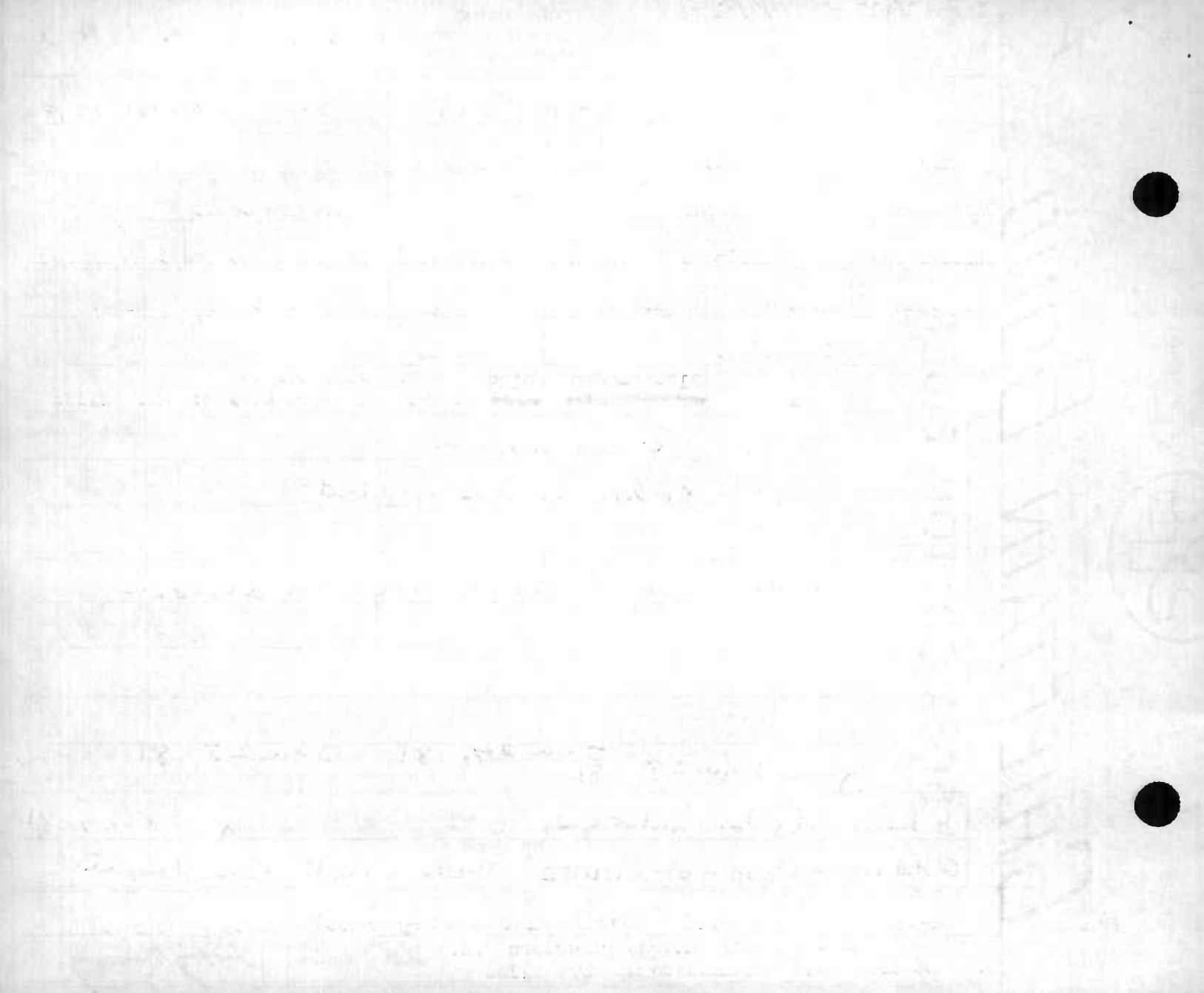
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REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>PRESTON - KNIGHT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 28, 1981</b>			2b. HOUR <b>10 A M</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 26, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Randallstown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Travel Agent-American Express</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. CITY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rockdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3440 Ripple Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edwin Knight</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Hardy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW 1</b>		16b. SOCIAL SECURITY NO. <b>212-05-9850</b> <b>911-10-6440</b>		17. INFORMANT <b>Mrs. Ethel Knight</b> <b>9109 Liberty Rd. Randallstown, MD. 21133</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arteriosclerotic Cardio-vascular disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1981</b> to <b>June 28, 1981</b> , that (I) (we) last saw the deceased alive on <b>June 28, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.									
22b. SIGNATURE <b>Sharon Pourmotabbed, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>6-24-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHASSEN POURMOTABBED</b>				22e. ADDRESS <b>Baltimore County Gen. Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>			
24. FUNERAL DIRECTOR <b>Loring Byers Funeral Directors, P.A.</b> NAME ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>				25a. DATE REC'D BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Loring Byers</b>			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH-16 25M  
(VRA 15, 4) 1/79

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of the present form should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must submit such notice.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8114745	
1. FOR STATE REGISTRAR <u>Julian</u>		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <u>Julian</u> <u>Kolakowski</u>		2a. DATE OF DEATH MONTH DAY YEAR <u>June 10, 1981</u> 2b. HOUR <u>5:30 AM</u>	
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>May 7, 1898</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Poland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	6. AGE (IN YEARS LAST BIRTHDAY) <u>83</u> YRS. <u>MONTHS</u> <u>DAYS</u> <u>HOURS</u> <u>MIN.</u>	
10. CITY OR TOWN OF DEATH <u>Upper Falls</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Box 33 Upper Falls Md</u>	9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore County</u> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <u>Roll Shop</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Beth Stell</u>	
13a. STATE <u>Maryland</u> 13b. COUNTY <u>Baltimore</u> 13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <u>Box 33 Upper Falls Md.</u>	
14. FATHER'S NAME FIRST <u>Julian</u> MIDDLE <u>Kolakowski</u> LAST		15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO <u>216-10-3150</u> 17. INFORMANT ADDRESS <u>Box 33</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>December 1, 1981</u> to <u>June 10, 1981</u> , that (I) (we) last saw the deceased alive on <u>June 1, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Phyllis K. Pullen MD</u> DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/10/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Phyllis K. Pullen</u>		22e. ADDRESS <u>2807 Jerusalem Rd, Kingsville, Md 21087</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>June 13-1981</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Of Mary</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Walter Dabrowski</u> ADDRESS <u>1005 Dundalk Ave. 21224</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 12 1981</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

Walter Dabrowski 1005 Dundalk Ave. 11214

June 13-1981 Secured Name of Mary

Baltimore

Ms.

Pl. W. K. Dabrowski

June 13-1981

ASCD

the City of Baltimore

11-10-810 the Honorable Nicholas Kozlowski Upper Falls Md. 21152

Julian Kozlowski

Baltimore

Box 23 Upper Falls Md.

Box 23 Upper Falls Md.

Box 23

Box 23



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

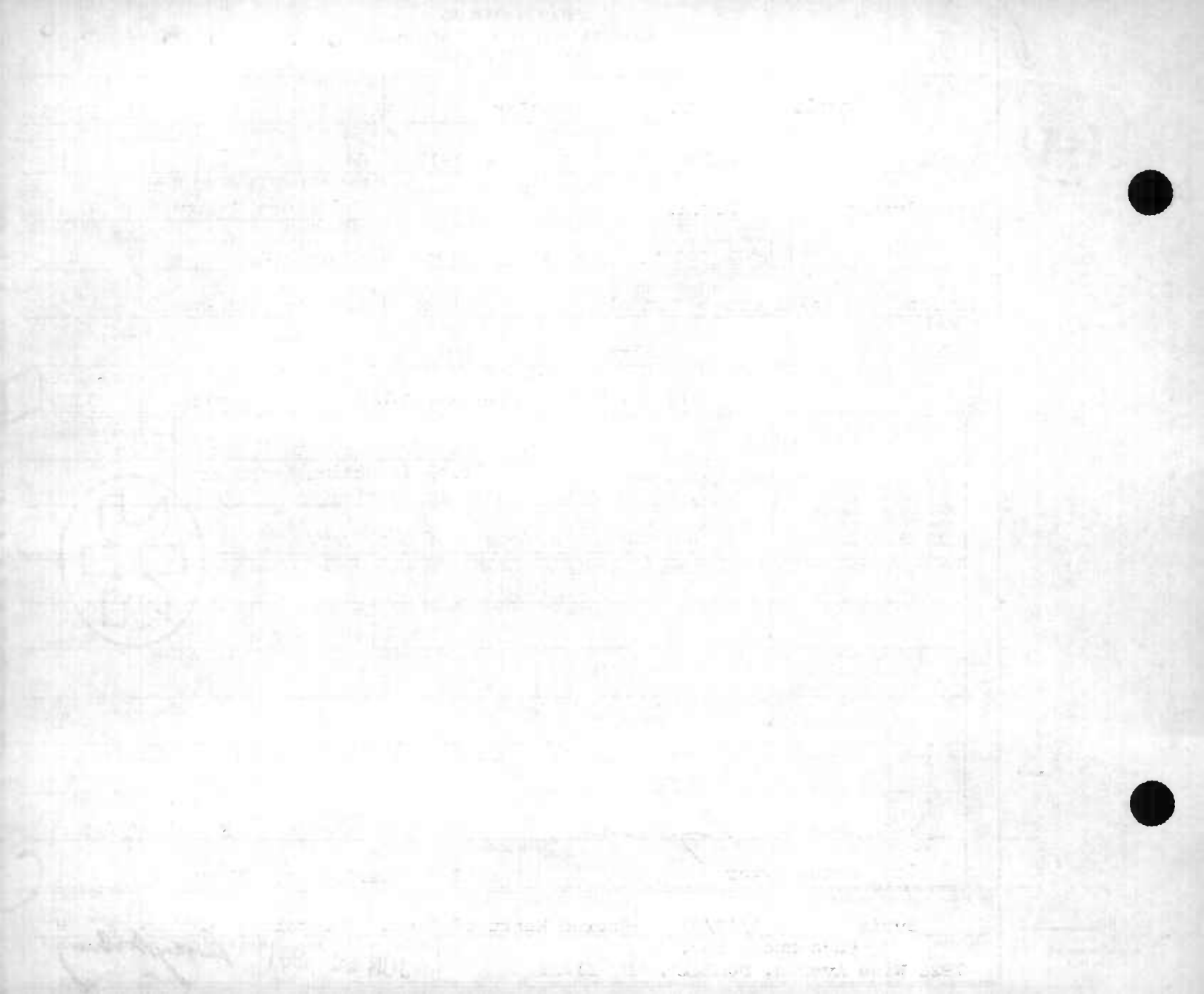
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 4 6			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Cecelia D. Kolar</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>6 9 81</b>		2b. HOUR <b>10:03AM</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 8 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N. Charles St. 21204</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Dundalk</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2518 McComas Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Zilka</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ann</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>214-38-5781</b>		17. INFORMANT <b>Theodore Kolar</b>		ADDRESS <b>2518 McComas Avenue Balto. MD 21222</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Pulmonary Arrest Secondary to Upper GI Bleed</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>High Fecal Impaction Secondary to widespread Metastatic Ovarian CA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Mucinous Cyst Adenoma of the Ovary</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>6/8</b> , 19 <b>81</b> , to <b>6/9</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>6/9</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. Martha Ryker</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/9/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Martha Ryker</b>				22e. ADDRESS <b>6701 N. Charles St. 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/12/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart of Jesus</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dundalk Baltimore MD</b>	
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue, Dundalk, MD 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 11 1981</b>		25b. REGISTER'S SIGNATURE <i>[Signature]</i>	





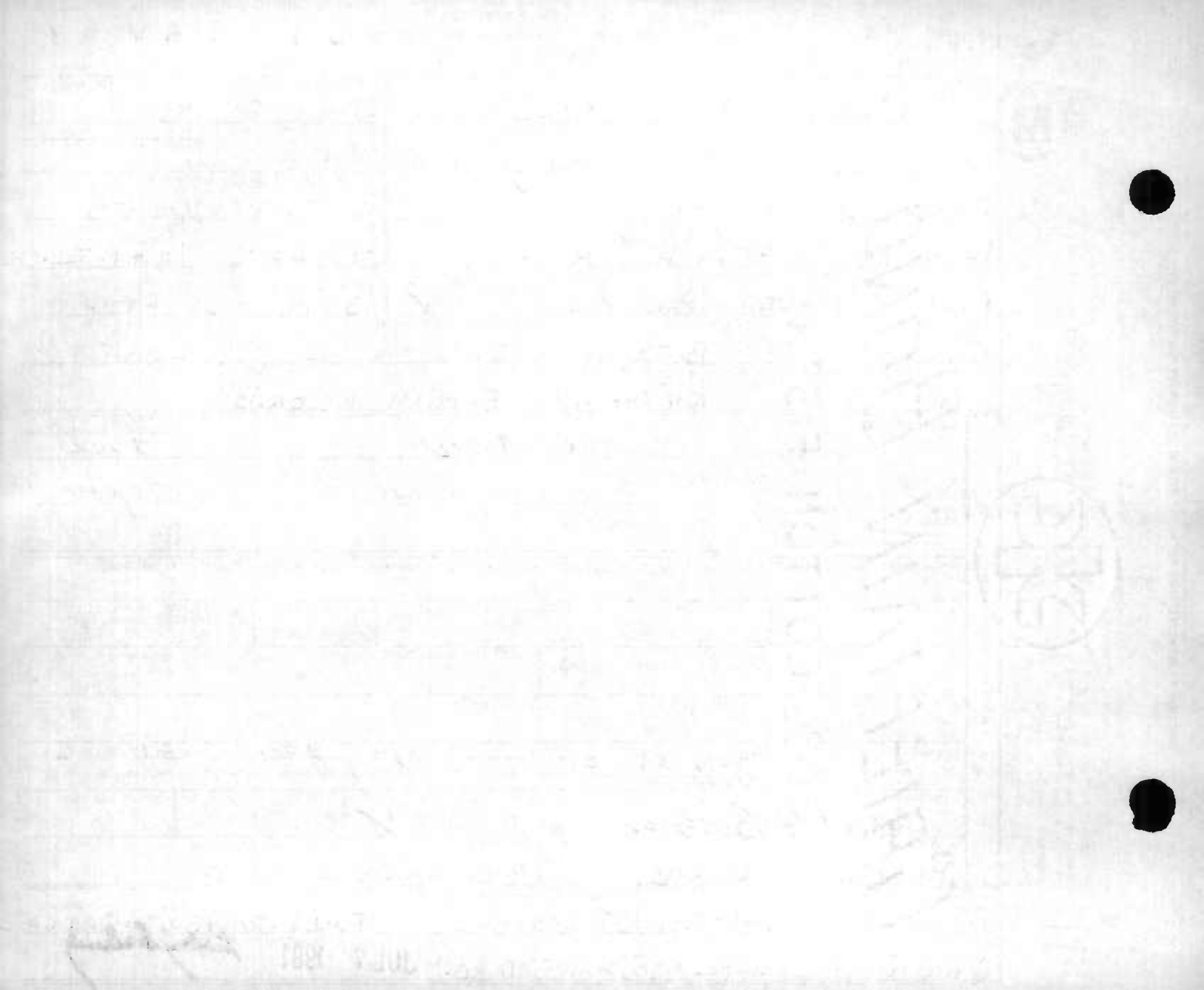
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 4 7 4 7				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
FIRST MARY M. KOLB					MONTH DAY YEAR June 28, 1981				
8. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		2b. HOUR	
FEMALE		WHITE		MONTH DAY YEAR FEB. 27, 1910		71 YRS.		M	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				BALTIMORE COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
PARKVILLE		3519 HISS AVE.				OPERATOR		L. + P. TEL. CO.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
13b. STATE 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3519 HISS AVE.		
14. FATHER'S NAME (FIRST MIDDLE LAST)					15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)				
WILLIAM BOTTLER					JANE C. DUNN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS		
NO					216 24 3619		FAMILY RECORDS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 1749 CARCINOMATOSIS									3 weeks
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA GUT.									7 year
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
			HOUR A.M. MONTH DAY YEAR P.M. 19						
21d. INJURY OCCURRED			21e. PLACE OF INJURY		21f. LOCATION				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 19 1974 to June 19 81, that (I) (we) last saw the deceased alive on June 23 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
HAROLD H. BURNS					M.D.				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
HAROLD H. BURNS					8106 HARFORD ROAD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
BURIAL			7-1-1981		ST. JOSEPH'S		FULLERTON BALTO. MARYLAND		
24. FUNERAL DIRECTOR					25a. DATE REG'D. BY REGISTRAR		25b. INITIALS OF REGISTRAR		
EVANS FUNERAL CHAPEL 8800 HARFORD RD.					JUL 7 1981				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

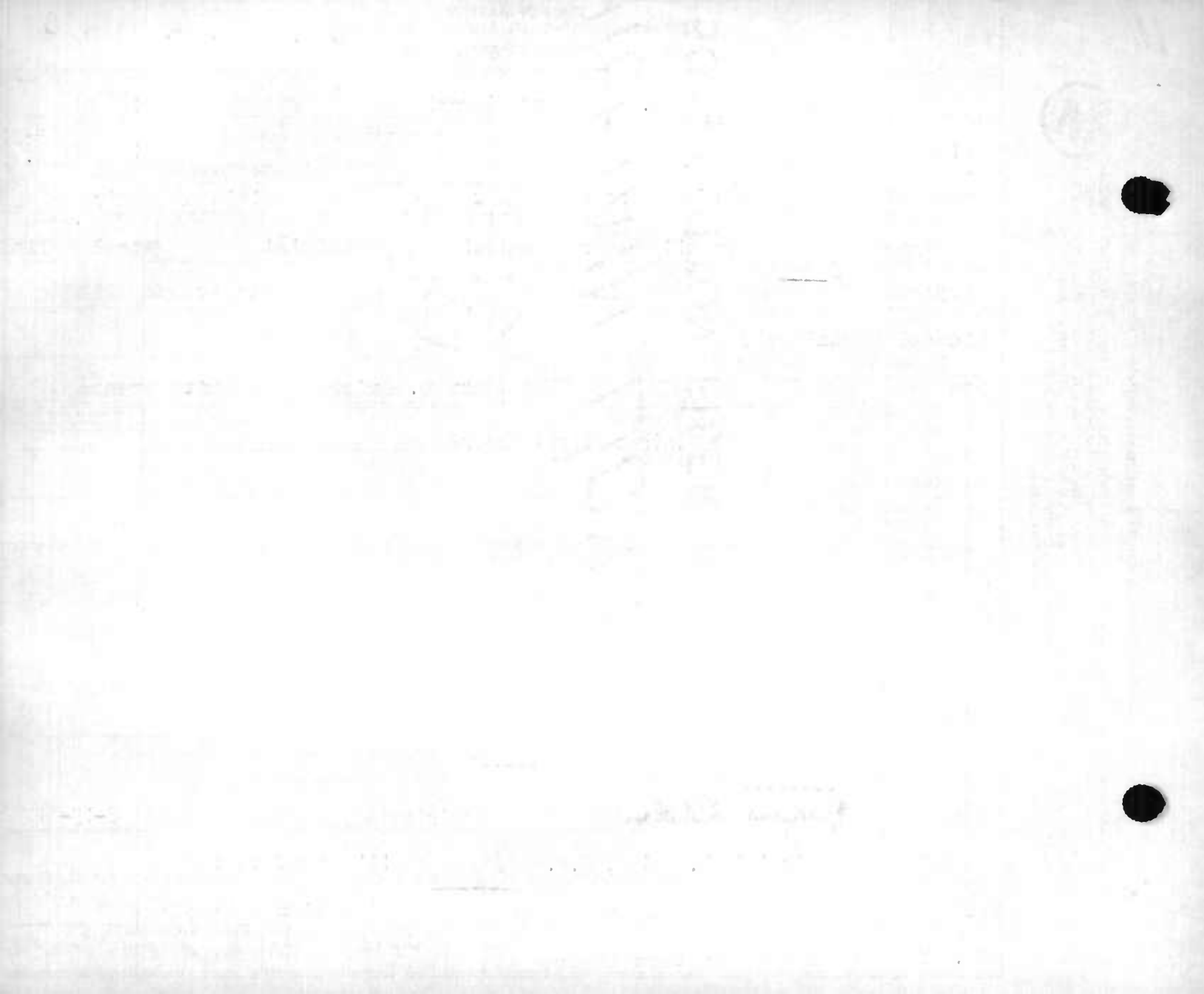
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
John J. Korzniewski			XX MONTH DAY YEAR 6 15 19 81			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR	
Male	White	12 23 00	81 YRS.	MONTHS DAYS HOURS MIN.		6 15 19 81	5:21 a. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		United States				Baltimore County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Essex		Franklin Square Hospital				Machinist		Steel & Tin
13a. STATE			13b. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland			Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	4609 White Avenue 21206			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				
Michael Korzniewski				Mary Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
yes			215 03 2352		John D. Bricko 4609 White Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 4310 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Virginia L. Dolan			M.D. Assistant			6-15-81		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Virginia L. Dolan, M.D.			111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		6 18 81		Holy Rosary		Baltimore Maryland		
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Wm. Fialkowski				2009 Eastern Avenue		JUN 19 1981		



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Bureau after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 7 4 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN J. KRAUK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 27 81</b>			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 4 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1021 EASTERN AVE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MO</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FREDERICK KRAUK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNIK</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-05-7654</b>		17. INFORMANT ADDRESS <b>OWENDEEMS TOWNSEND RD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery disease</b> (c) <b>arteriosclerotic cardiovascular disease</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>5 years</b> <b>10 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3 April 1976</b> to <b>27 June 1981</b> , that (I) (we) last saw the deceased alive on <b>6 May 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>M. Rainess M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6-29-81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MORRIS RAINESS, M.D.</b>				22e. ADDRESS <b>1105 OLD EASTERN AVE Balto Md 21221</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>J. G. CONNELLY SONS 300 MALE</b>				25a. DATE REC'D. BY REGISTRAR <b>JUL 2 - 1981</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

W. J. KENNEDY

✓

W. J. KENNEDY

OLD FASHIONED

W. J. KENNEDY

W. J. KENNEDY

W. J. KENNEDY

W. J. KENNEDY

W. J. KENNEDY

W. J. KENNEDY

W. J. KENNEDY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

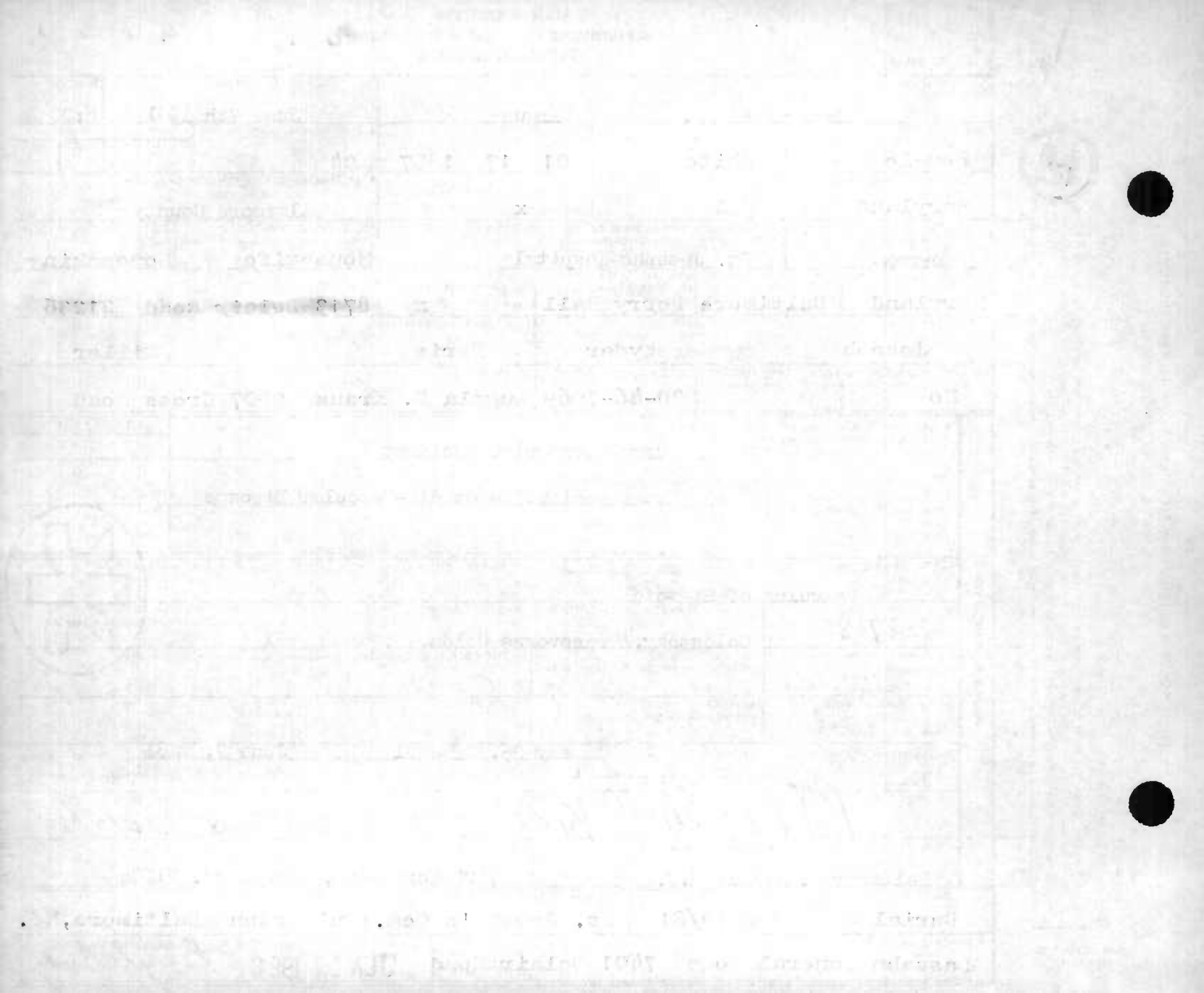
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1- FOR STATE REGISTRAR										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH		DAY	YEAR
Catherine M. Kraus					June 7th 1981		6:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS
Female		White		MONTH DAY YEAR 01 17 1887		94 YRS.		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		USA				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Josephs Hospital				Housewife		Homemaking		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			
Maryland			Baltimore		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS				
FIRST MIDDLE LAST Joseph Snyder			FIRST MIDDLE LAST Marie Miller			8713 Belair Road 21236				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No			220-46-7969		Angela B. Kraus 9807 Cross Road					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Volvulus of Sigmoid										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
5-27-81		Colostomy, Transverse Colon, L.				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (✓) (this hospital) attended the deceased from May 25, 19 81, to June 7, 19 81, that (✓) (we) lost saw the deceased alive on June 7, 19 81, and that in (our) (my) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)										
22b. SIGNATURE Baltasar B. Velez, M.D.						22c. DATE SIGNED 6/7/81		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		
Baltasar B. Velez, M.D.						7620 York Road, Towson Md. 21204		22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D BY REGISTRAR		
Burial		6/10/81		St. Joseph's Cem.		Fullerton Baltimore, Md.		JUN 11 1981		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Lassahn Funeral Home 7401 Belair Road						JUN 11 1981		Baltasar B. Velez		

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 4 7 5 1				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Helen Mary KRAWCZYK					June 4, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
F		W		3/16/95		86		7:07 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
PA.		USA				Baltimore County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
ROSSVILLE		FRANKLIN SQ.		TAILOR					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD.		BALTO		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2515 BAYSIDE DR	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO		213101965		HELEN BANASZKIEWICZ ABOVE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. DUE TO, OR AS A CONSEQUENCE OF		21. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		Cardiopulmonary arrest		Congestive heart failure		Severe arteriosclerotic cardiovascular disease			
4292									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22. I certify that (X) (this hospital) attended the deceased from June 4, 1981, to June 4, 1981, that (X) (we) last saw the deceased alive on June 4, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Henry Sacerio		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		6/4/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
		9000 Franklin Square Dr., 21237		BURIAL		6/8/81		ST. STANISLAUS	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE RECEIVED BY REGISTRAR		24d. REGISTRAR'S SIGNATURE			
Connelly F.H.		300 Mare Ave		JUN 10 1981					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 7 5 2	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL ANNE KRENGEL</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>June 13, 1981</b>			2b. HOUR <b>7:15 pm</b>		
3. SEX <b>female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 11 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Presbyterian Home of Maryland, Inc.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>						13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>412 Evesham Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest A. Krengel</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna D. Gelletly (also spelled Annie)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>215-10-8600</b>		17. INFORMANT ADDRESS <b>(Mrs.) Cordelia S. Manger 202 S. Rolling Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRAL ARTERIO SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERAL ARTERIO SCLEROSIS</b>										APPROXIMATE PERIOD BETWEEN ONSET AND DEATH <b>Days</b> <b>4370</b> <b>4 yrs</b> <b>4 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>JUNE 10</b> , 19 <b>81</b> , to <b>JUNE 13</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive on <b>JUNE 10</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>S. J. VENABLE, JR. M.D.</b>				DEGREE				22c. DATE SIGNED <b>6-15-81</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S. J. VENABLE, JR. M.D.</b>				22e. ADDRESS <b>7215 YORK RD. BALTIMORE MD 21242</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>6/13/81</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>						ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 4 7 5 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Katherine A. Krieger					MONTH DAY YEAR 6 2 1981				
3. SEX Female					2b. HOUR A 7.05 M				
4. RACE White					5. DATE OF BIRTH				
					MONTH DAY YEAR 2 3 1904				
6. AGE (IN YEARS LAST BIRTHDAY)					7. AGE (IN YEARS LAST BIRTHDAY)				
77					77				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
Md.					USA				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					Baltimore County MD.				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
Midhurst					6306 Blenheim Rd.				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Homemaker									
13a. STATE					13b. COUNTY				
Md.					Balto				
13c. CITY OR TOWN					13d. INSIDE CITY LIMITS?				
Midhurst					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
Charles S. Austin					Caroline Koch				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
no					216 46 2993				
17. INFORMANT					ADDRESS				
Mark A. Krieger Jr					702 Stone Barn Ct.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>substatie carcinoma of colon</i>									
1539 DUE TO, OR AS A CONSEQUENCE OF									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
June 1980									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
ca of colon									
20a. AUTOPSY?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY									
HOUR A.M. MONTH DAY YEAR									
P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION									
STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 71</i> 19 <i>58</i> , to <i>6/2</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>6/1</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
DEGREE									
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22c. DATE SIGNED									
4/2/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)									
Franklin E. Leslie M.D.									
22e. ADDRESS									
3501 St. Paul St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)									
Burial									
23b. DATE									
6/4/1981									
23c. NAME OF CEMETERY OR CREMATORY									
Lorraine Cemetery									
23d. LOCATION									
CITY OR TOWN COUNTY STATE									
Woodlawn Balto Md.									
24. FUNERAL DIRECTOR									
NAME Mitchell-Wiedef 1d Home 6500 York Rd.									
25a. DATE REC'D. BY REGISTRAR									
JUN 9 1981									
25b. REGISTRAR'S SIGNATURE									

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44814 101103 11818

1201 St. W. A. 11.

Franklin A. Leslie M.A.

number of days of absence from duty

1201 St. W. A. 11.

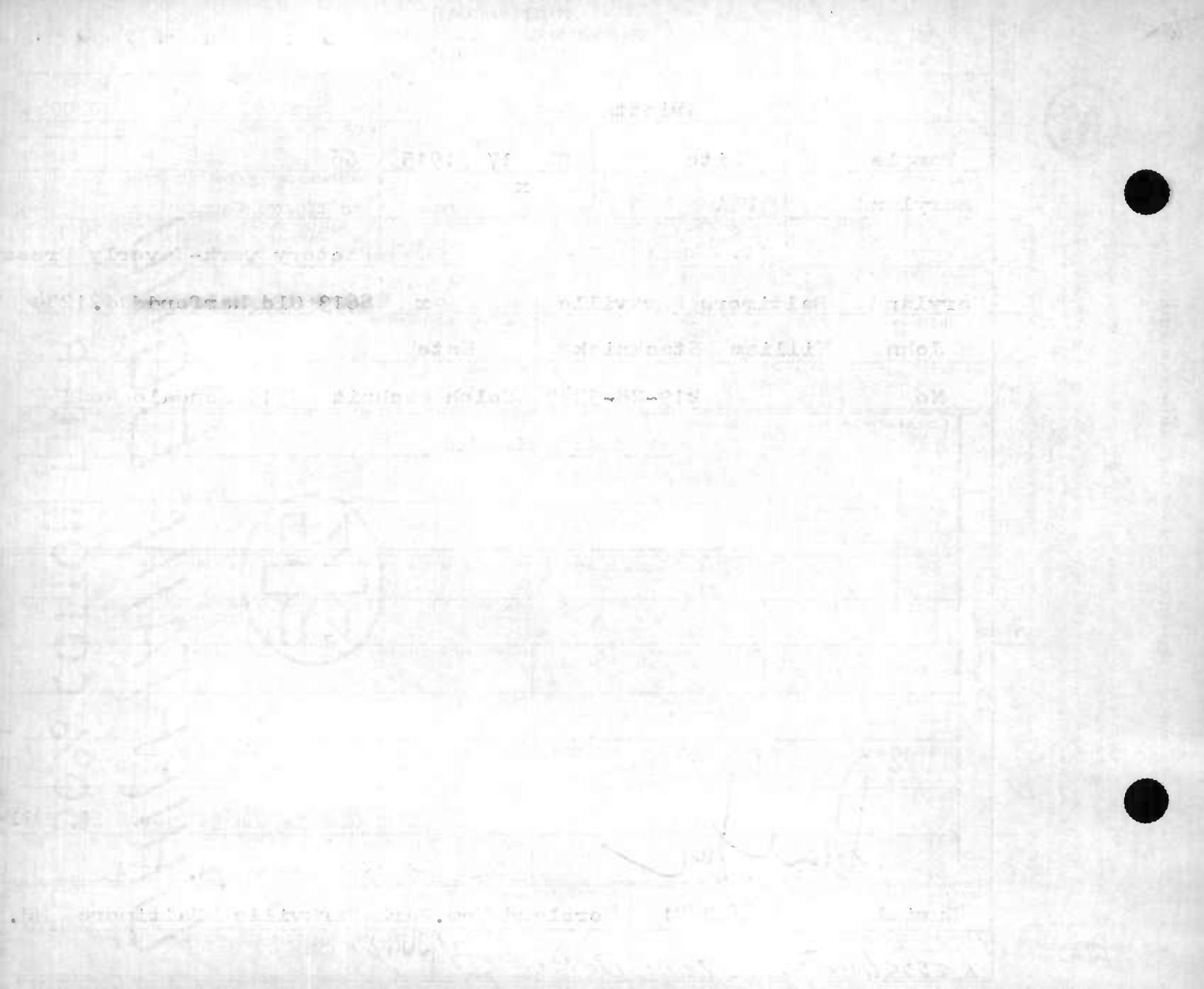
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 7 5 4			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Mildred Arietta Lachnit				2a. DATE OF DEATH MONTH DAY YEAR June 19, 1981		2b. HOUR 1:00 p.m.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 17 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory work-		12b. KIND OF BUSINESS OR INDUSTRY Laverly Press	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville	
14. FATHER'S NAME FIRST MIDDLE LAST John William Stacknick				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 219-28-5343		17. INFORMANT ADDRESS Adolph Lachnit 8315 Kendale Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized peritonitis 5672 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 14, 1981 to June 19, 1981, that (I) (we) lost saw the deceased alive on June 19, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DEGREE Samuel H. Lee, M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED June 19, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Samuel H. Lee, M.D.				22e. ADDRESS 7620 York Road, Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/22/81		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Baltimore Md.	
24. FUNERAL DIRECTOR NAME Lassabn F.H.				24a. INTERREG. TO REGISTRAR 7401 Belair Rd.		24b. REGISTRAR'S SIGNATURE JUN 21 1981	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 1 4 7 5 5									
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth C Lacy</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6-5-81</b>					2b. HOUR <b>4:00 am</b>				
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12-1-1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS <b>91</b>		IF UNDER 24 HRS HOURS MIN. <b>91</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore-Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltto. County</b>								
10. CITY OR TOWN OF DEATH <b>Towson, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Maris Hospice</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>clerical</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Union Brothers</b>						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13. STATE <b>Maryland</b>					13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMIT YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1437 Towson J. Street</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Lacy</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Josephine Allender</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>212-05-8809</b>		17. INFORMANT ADDRESS <b>Stella Maris Hospice-Dulaney Valley</b>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>0389 Bilateral Pneumonia</b> IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Sepsis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF: PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <b>2-11</b> 19 <b>81</b> , to <b>6-5</b> 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>6-4</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Doctor NaKhuda</b>				DEGREE				22c. DATE SIGNED <b>6/5/81</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Doctor NaKhuda M.D.</b>				22e. ADDRESS <b>Stella Maris Hospice - Towson Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-8-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cattedara Cemetery Baltimore</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Maryland</b>								
24. FUNERAL DIRECTOR NAME <b>Charles L. Stevens Funeral Home, Inc.</b>				ADDRESS <b>1501 E. Fort Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 9 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Harry K. ...</b>						

2-2-31 4:00pm

Female Cuckoo 12-1-19 91

Buttins Hill 11211

Tamara, Md. still in the same place

W. J. 11211

Frank 11211

11211

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 5 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JENNIE LANCIE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 15, 1981</b>		2b. HOUR <b>9:00 PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 15, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TOWSON Baltimore Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6701 N CHARLES ST GBMC</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Towson</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>28 Allegheny Avenue</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Anthony Villella</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Angela Mercury</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-26-6604</b>		17. INFORMANT ADDRESS <b>Mr. Ralph Lancie same as # 13</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

5860

IMMEDIATE CAUSE (a) **UREMIC POISONING**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

(b) **RENAL FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 2, 1981</b> to <b>JUNE 15, 1981</b> that (I) (we) lost saw the deceased alive on <b>JUN 15, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Blair P. Grubb</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>6/15/81</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR BLAIR P GRUBB</b>		22e. ADDRESS <b>GBMC</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>6/18/81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Ruck Towson Funeral Home, Inc. 1050 York Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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JUN 12 1964  
U.S. AIR FORCE  
HEADQUARTERS  
AFMPC  
WRIGHT-PATTERSON  
AFB  
OHIO





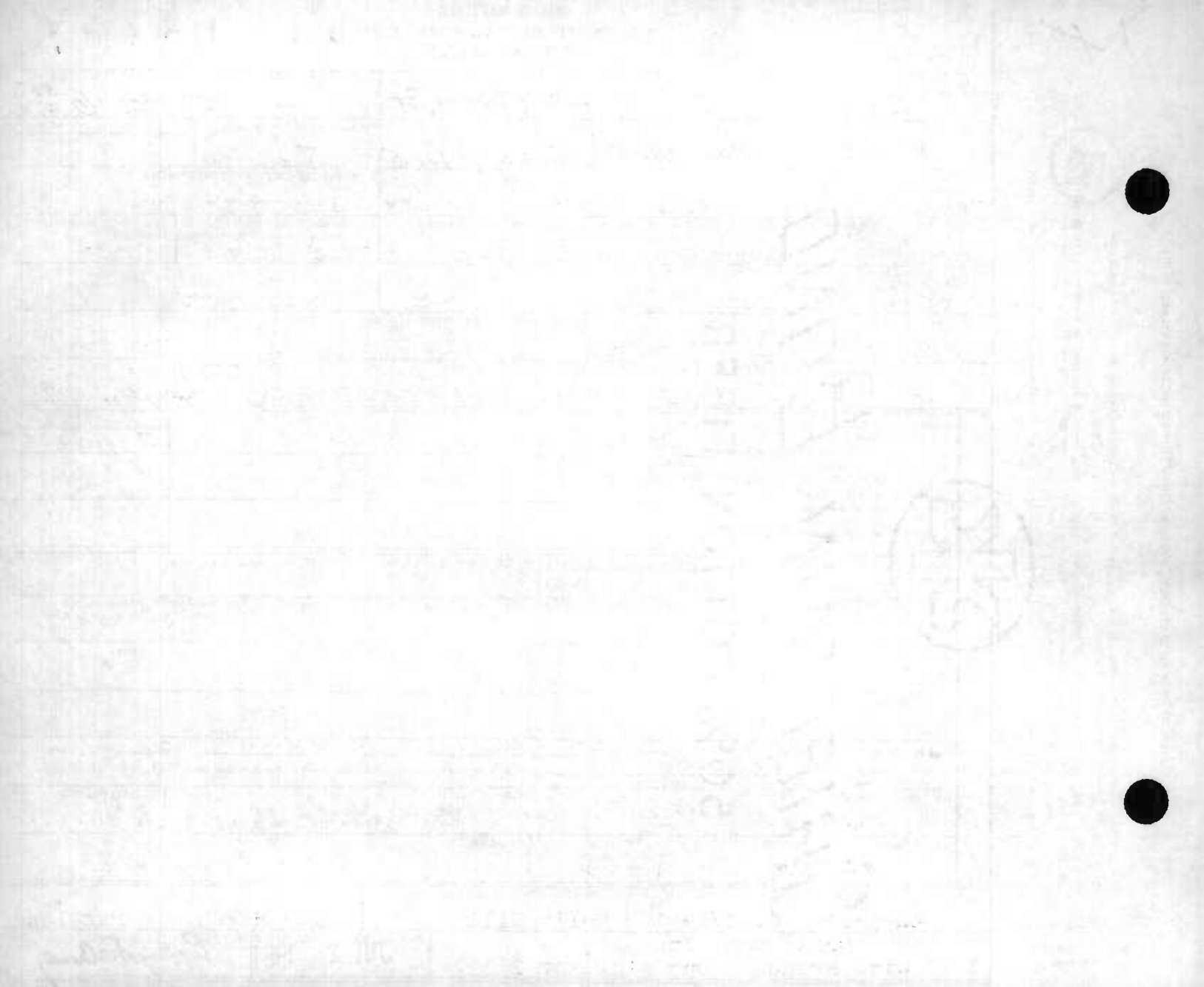
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-358-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	7	5	7	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>ELROY C. Langford, Sr.</b>										2a. DATE OF DEATH MONTH DAY YEAR <b>June 30 1981</b>				2b. HOUR <b>6:55 A M</b>			
3. SEX <b>MALE</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>January 4 1905</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.								
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Nursing Home</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Truck Driver</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>					
13a. STATE <b>Maryland</b>										13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Essex</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5 Brett Court</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur E. Langford</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie M. Mathias</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-10-3966</b>			17. INFORMANT ADDRESS <b>767 Seawall Road</b> <b>Elroy C. Langford, Jr. - Essex, MD. 21221</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <b>23 April 81</b> to <b>30 June 81</b> , that (I) (we) lost saw the deceased alive on <b>29 June 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Walter T. Kees</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>30 June 1981</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WALTER T. KEES</b>					22e. ADDRESS <b>Monkton Md 21111</b>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7/3/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>White Marsh Maryland</b>								
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>										25a. DATE RECEIVED BY REGISTRAR <b>JUL 2 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>					

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 8 1 4 7 5 8  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
John T. Langmead					6 27 81					1:50 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
MALE	WHITE		OCT 24 1914		66		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MD.	U.S.A.				BALTIMORE COUNTY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
RANDALLSTOWN		BALTO CO. HOSPITAL				RETAIL MGR		LIQUOR STORE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MD		BALTO.		WOODMOOR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3506 ESSEX RD. 21207			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
JOHN T. LANGMEAD SR.		MARY R. O'BRIEN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
NO		213-10-7979		MARY E. LANGMEAD (SAME)							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardio-respiratory arrest  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Ch. Lungs -  
DUE TO, OR AS A CONSEQUENCE OF  
(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/27</u> , 19 <u>81</u> , to <u>6/27</u> , 19 <u>81</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>6/27</u> , 19 <u>81</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> did (did not) view the body after death.							
22b. SIGNATURE <u>A. Memari</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>6/27/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
		5401 OLD COURT RD.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		6/30/81		WOODLAWN		WOODLAWN BALTO. MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NEWELL F.H. PIKESVILLE, MD.				JUL 1 1981		<u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

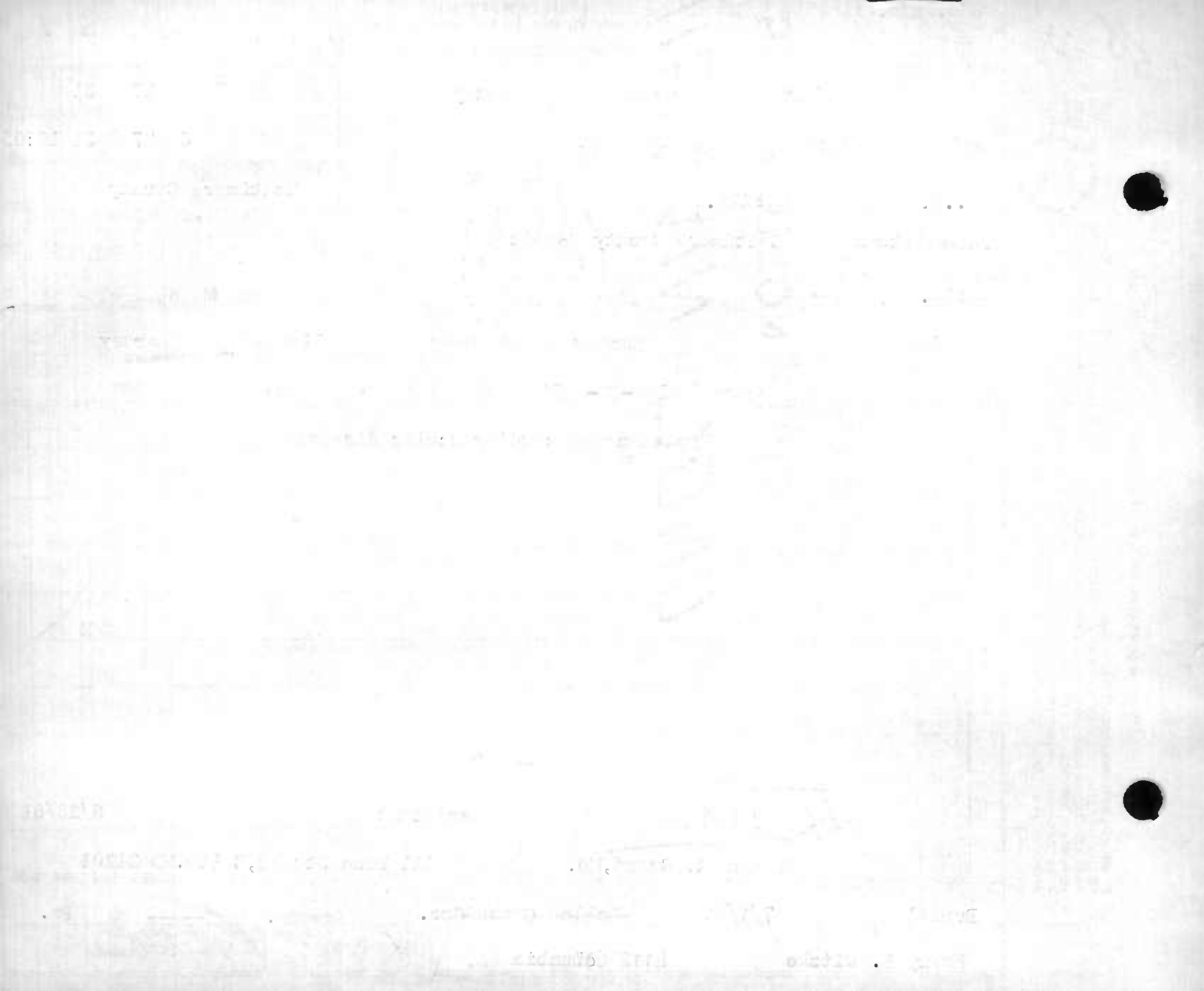
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14759	
1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Edward			LAST Larney		
2a. DATE OF DEATH		KNOWN ESTIMATED		MONTH 6		DAY 27		YEAR 1981		2b. HOUR M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 2 23 38		6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 27 1981	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.			7b. CITIZEN OF WHAT COUNTRY? Phila. USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10. CITY OR TOWN OF DEATH Randallstown			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive			12b. KIND OF BUSINESS OR INDUSTRY Transportation		
13a. STATE Phila. Md.			13b. CITY OR TOWN Howard			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 3806 Spring Meadow Dr.		
14. FATHER'S NAME FIRST MIDDLE LAST William Larney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Larney								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			(IF YES, GIVE WAR OR DATES) Navy Reserve			16b. SOCIAL SECURITY NO. 160-32-2219			17. INFORMANT ADDRESS Elizabeth A. Larney, same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>H. R. Guard</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 6/28/81		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, MD.			ADDRESS 111 Penn Street, Balto. MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/1/81		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery - Holley Cross Ctr.			23d. LOCATION CITY OR TOWN COUNTY STATE Yeadon Pa.			
24. FUNERAL DIRECTOR NAME Harry H. Witzke			ADDRESS 4112 Columbia Rd.			25a. DATE REC'D. BY REGISTRAR JUN 30 1981			25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCreedy</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (original).

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 1 4 7 6 0		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2r. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
BENNY LASPINA						6/11/81					1P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		W		4/21/11		70 YRS.		MONTHS DAYS		HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
PA		USA				BALTO. COUNTY MD.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
ESSEX		42 RIVERSIDE RD.										
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY										
		STEEL										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MD		BALTO		ESSEX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		42 RIVERSIDE RD.				
14 FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
ALFIO LA SPINA						VUK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS						
UNK				212 05 6874		ELIZABETH LASPINA ABOVE						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory failure</u> 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Malignant tumor (carcinoma) of the brain.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>the brain.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>4 months</u> <u>÷</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>none.</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
March 6, 1981			Cancer of the brain			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
						N/A						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
						÷						
22a. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1981</u> to <u>June 10, 1981</u> , that (I) (we) lost saw the deceased alive on <u>June 10, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Eugene C. Baumann, M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>June 12, 1981</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eugene C. Baumann</u>						22e. ADDRESS <u>413 Eastern Blvd Baltimore, Md 21221</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			6/13/81		M ORELAND S			BALTO. MD				
24 FUNERAL DIRECTOR NAME ADDRESS <u>J. G. CONNELLY 504 S 300 MACE</u>						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
						JUN 16 1981						





1. The first part of the report is a general introduction to the project. It describes the purpose of the study and the objectives that were set at the beginning.

2. The second part of the report is a detailed description of the methodology used in the study. This includes information about the data sources, the sampling methods, and the statistical techniques that were employed.

3. The third part of the report presents the results of the study. This section includes tables, graphs, and other visual aids that help to illustrate the findings.

4. The fourth part of the report is a discussion of the results. This section explains the meaning of the findings and how they relate to the research objectives.

5. The fifth part of the report is a conclusion. This section summarizes the main findings of the study and provides some suggestions for future research.

6. The sixth part of the report is a list of references. This section includes all of the sources that were used in the study.

7. The seventh part of the report is an appendix. This section includes any additional information that is relevant to the study but that does not fit into the main body of the report.

8. The eighth part of the report is a glossary. This section defines the key terms and concepts that are used in the report.

9. The ninth part of the report is a bibliography. This section lists all of the books, articles, and other sources that were consulted during the research.

10. The tenth part of the report is a list of figures. This section includes all of the graphs, tables, and other visual aids that are used in the report.

10x6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 1 4 7 6 1 REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Gordon Benton Leatherwood				2a. DATE OF DEATH MONTH DAY YEAR June 26, 1981				2b. HOUR M			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Woodmoor		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3504 Fairview Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret-Analyst-Balto			12b. KIND OF BUSINESS OR INDUSTRY Housing Auth.		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodmoor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3504 Fairview Rd 21207			
14. FATHER'S NAME FIRST MIDDLE LAST Ellis Leatherwood				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17. INFORMANT Balto. Md. ADDRESS 21207 Wm E. Leatherwood 2633 West Park Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Asphy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u> 15 year										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic pancreatitis</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, HISTORY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NEED WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24/75</u> 19 <u>80</u> to <u>6/26/81</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>9/24/75</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. Joseph Shearn				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 6/27/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph Shearn</u>				22e. ADDRESS 6715 Park Heights Ave.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6/29/81		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Balto Md			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, P.A.				8728 Liberty Rd. Randallstown, Md. ADDRESS		21133		25a. DATE REC'D BY REGISTRAR JUN 30 1981		25b. REGISTRAR'S SIGNATURE <u>Loring Byers</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 6 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Vaughn Burton Ledford			2a. DATE OF DEATH MONTH DAY YEAR June 4, 1981			2b. HOUR M	
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1923		6 AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10 CITY OR TOWN OF DEATH Middle River 21220		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1204 Fuselage Ave.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder	
13a STATE Maryland		13b CITY OR TOWN Baltimore		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d STREET ADDRESS 1204 Fuselage Ave. 21220	
14 FATHER'S NAME FIRST MIDDLE LAST Smith Ledford				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geneva Thomas			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17 INFORMANT ADDRESS Madeline Ledford, Wife Same			

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Cor. art. disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH 2mm	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

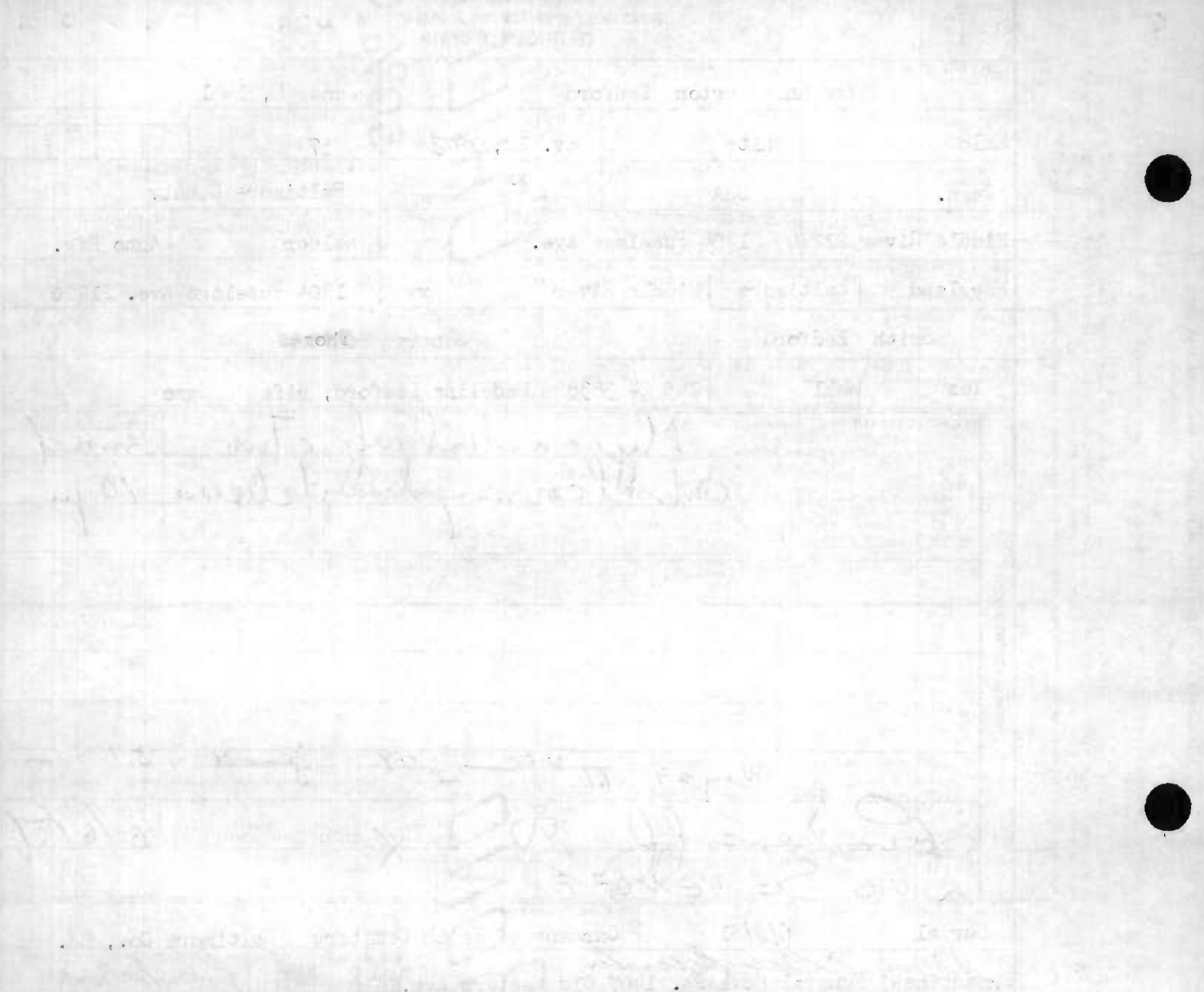
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from May 29, 1981, to June 4, 1981, that (I) (we) last saw the deceased alive on May 29, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE Louis Semeroff		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/6/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LOUIS SEMEROFF		22e. ADDRESS					

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 6/8/81		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.	
24 FUNERAL DIRECTOR Buzdinski Funeral Home Pa. 1407 Old Eastern Ave.				25a. DATE REC'D. BY REGISTRAR JUN 8 1981		25b. REGISTRAR'S SIGNATURE Petryk the County	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8114763	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Rebecca D. Lee</b>					2a. DATE OF DEATH MONTH <b>6</b> DAY <b>26</b> YEAR <b>1981</b>		2b. HOUR <b>11A</b> M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>11</b> YEAR <b>1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Towson Con. Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>500 W. University Pkw.</b>			
14. FATHER'S NAME FIRST <b>Wm</b> MIDDLE <b>S</b> LAST <b>Diffenderffer</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Estelle</b> MIDDLE <b></b> LAST <b>Anderson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>220-44-4373</b>		17. INFORMANT <b>Mrs Wm. H. Alexander</b>		ADDRESS <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respiratory failure</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>As a consequence of cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/13</b> , 19 <b>81</b> , to <b>6/26</b> , 19 <b>81</b> , that (I) (we) last saw the deceased alive on <b>4/13</b> , 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Norman R. Freeman</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/29/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN R. FREEMAN</b>				22e. ADDRESS <b>11 W. 29th St., Baltimore</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/29/1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemt.</b>				23d. LOCATION CITY OR TOWN <b>Pikesville</b> COUNTY <b></b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 6 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gertrude Doris Levin				2a. DATE OF DEATH MONTH DAY YEAR June 22, 1981			
3. SEX Female				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 28 09	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Eastpoint		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7845 Wynbrook Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Eastpoint	
14. FATHER'S NAME FIRST MIDDLE LAST John Slezeska				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophie ?			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-03-1248		17. INFORMANT ADDRESS David Levin 7845 Wynbrook Rd. 21224	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCD with old MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 yrs.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>6-13-19-79</u> , to <u>6-22-19-81</u> , that (1) (we) lost saw the deceased alive on <u>6-15-19-81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>J. Ardaiz</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/23/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose Ardaiz, M.D.				22e. ADDRESS 7838 Eastern Ave. Balto. MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-25-81		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE 7225 Eastern Blvd. Balto., Md.	
24. FUNERAL DIRECTOR NAME C.S. Zeiler & Son Inc. 6224 Eastern Ave. 21224				25a. DATE REC'D. BY REGISTRAR JUN 23 1981		25b. REGISTRAR'S SIGNATURE <u>Robert M. ...</u>	

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8114765

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ANNA LEVY			2a. DATE OF DEATH MONTH DAY YEAR JUNE 1, 1981			2b. HOUR P. 12:25 M			
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR SEPT. 8, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.			
10 CITY OR TOWN OF DEATH PIKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PIKESVILLE NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY				13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST MYER TUROW				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ETHEL ZVENEGERSKY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 213-74-0394		17 INFORMANT MR. DAVID E. LEVY 2500 W. BELVEDERE AVE., APT. 812 BALTO., MD 21215			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke (recurrent)</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASEVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/27/81 to 6/1/81, that (I) (we) lost saw the deceased alive on 5/27/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE Harold B Bobb MD						DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD B. BOB, M.D.						22e. ADDRESS 7220 PARK HTS. AVE. BALTO., MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6/2/81		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY BALTIMORE COUNTY MARYLAND STATE		
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR JUN 3 1981		25b. REGISTRAR'S SIGNATURE Kathy McCreedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

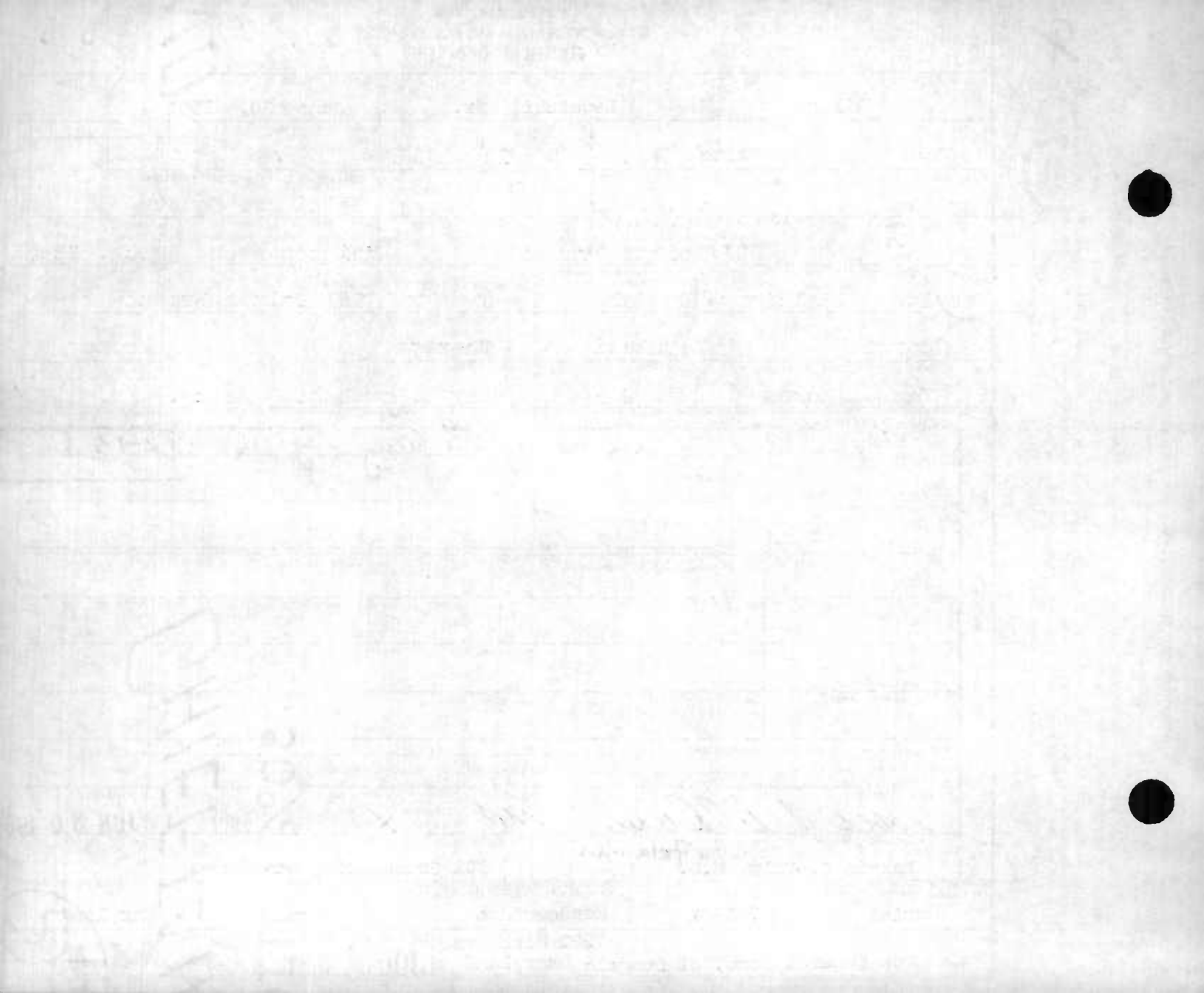
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert W. Lewetzki, Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 30, 1981</b>					2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 1932</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD				
10. CITY OR TOWN OF DEATH <b>Dundalk</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>981 Dalton Avenue</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Dundalk</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>981 Dalton Avenue</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Lewetzki</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theresa Kroner</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea</b>		17. INFORMANT <b>Betty L. Lewetzki</b>		ADDRESS <b>981 Dalton Ave. Balto., MD. 21224</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the lung. Sq cell</b> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-13-81</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Marvin J. Feldman</b>					DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>JUN 30 1981</b>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marvin J. Feldman, M.D.</b>					22d. ADDRESS <b>302 Greenspring Station</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>7-3-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Dorsey Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Duda-Ruck Funeral Home, of Dundalk Maryland</b>					25a. DATE REC'D. BY REGISTRAR <b>JUL 6 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH-16 30M 2/80  
(VRA 15, 4)

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna Georgivna Limansky			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1981			2b. HOUR 9:30 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10-17-1889		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Manor Care - Ruxton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Georgivna			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kaisa Brustman			13e. STREET ADDRESS 3714 Mayberry Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 173-01-1403A		17. INFORMANT ADDRESS Mr. Igor Limansky - 5803 East Ave. - 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD CHH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH acute 75 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (s) (this hospital) attended the deceased from 5/26 19 81 to 6/11 19 81, that (I) (we) most saw the deceased alive on 5/26 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (we) (did not) view the body after death.									
22b. SIGNATURE Richard Maffezzoli						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Maffezzoli						22e. ADDRESS 660 KENILWORTH, Towson, Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 6-15-81		23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Road-21206						25a. DATE REC'D. BY REGISTRAR JUN 16 1981		25b. REGISTRAR'S SIGNATURE Kathy McBrady	

MEDICAL CERTIFICATION

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Wm. C. Miller 18-475 Chain 100-129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 6 8			
1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Jean W. Linton</u>				2a. DATE OF DEATH MONTH <u>June</u> DAY <u>6</u> YEAR <u>'81</u>		2b. HOUR <u>4</u> <sup>15</sup> <sub>P</sub> M	
3. SEX <u>F</u>	4. RACE <u>W</u>	5. DATE OF BIRTH MONTH <u>5</u> DAY <u>8</u> YEAR <u>06</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>	
7a. BIRTHPLACE (COUNTRY) <u>Canada</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A. - Naturalized</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Towson</u> MD.	
10. CITY OR TOWN OF DEATH <u>Towson</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Stella Maris Hospice</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>R.N.</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
13a. STATE <u>Md.</u>				13b. COUNTY <u>Balto</u>		13c. CITY OR TOWN <u>Towson</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>F.</u> LAST <u>Woodworth</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Mary</u> MIDDLE <u></u> LAST <u>Caddell</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> (IF YES, GIVE WAR OR DATES) <u>-----</u>				16b. SOCIAL SECURITY NO. <u>212-32-1188</u>		17. INFORMANT <u>Arthur B. Linton Balto. Co., Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7140 Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Rheumatoid Arthritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Perferal Vascular Disease</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M.</u> <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Eddie Nakhuda</u>				DEGREE <u></u>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Eddie Nakhuda</u>				22e. ADDRESS <u></u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>June 9, '81</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION CITY OR TOWN <u>Baltimore Co., Md.</u> COUNTY <u></u> STATE <u></u>	
24. FUNERAL DIRECTOR NAME <u>William E. Johnson</u>				ADDRESS <u>8521 Loch Raven Blvd.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 8 - 1981</u>	
				25b. REGISTRAR'S SIGNATURE <u>Robert J. Brady</u>			

1871

2025 COLLECTION

UNIVERSITY OF MICHIGAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 7 6 9	
1 - FOR STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
LOLA MAE LIVINGSTON				06 25 81	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 04 25 95	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH HOSPITAL		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST McABEE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAMIE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 215-01-5421	
17. INFORMANT MAMIE ZELL RHEW				ADDRESS SAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarct</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Senile &amp; aged</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>19 80</u> to <u>4/16</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>4/14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dean K. Peterson				22c. DATE SIGNED 6/26/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/29/81		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL BALTIMORE CITY, MARYLAND	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME		ADDRESS 6500 YORK RD. BALTIMORE, MD.		25a. DATE REC'D. BY REGISTRAR JUN 30 1981	
25b. REGISTRAR'S SIGNATURE					

LOLA LIVINGSTON 06 27 21

FEMALE CAUCASIAN 04 25 92 BALTIMORE COUNTY

TOWSON ST JOSEPH HOSPITAL

MARYLAND BALTIMORE 100 CENTRE AVE

THE DISTRICT OF COLUMBIA

*Best medical report  
from Dr. [illegible]*

15 NOV 1951

*Dr. [illegible]*

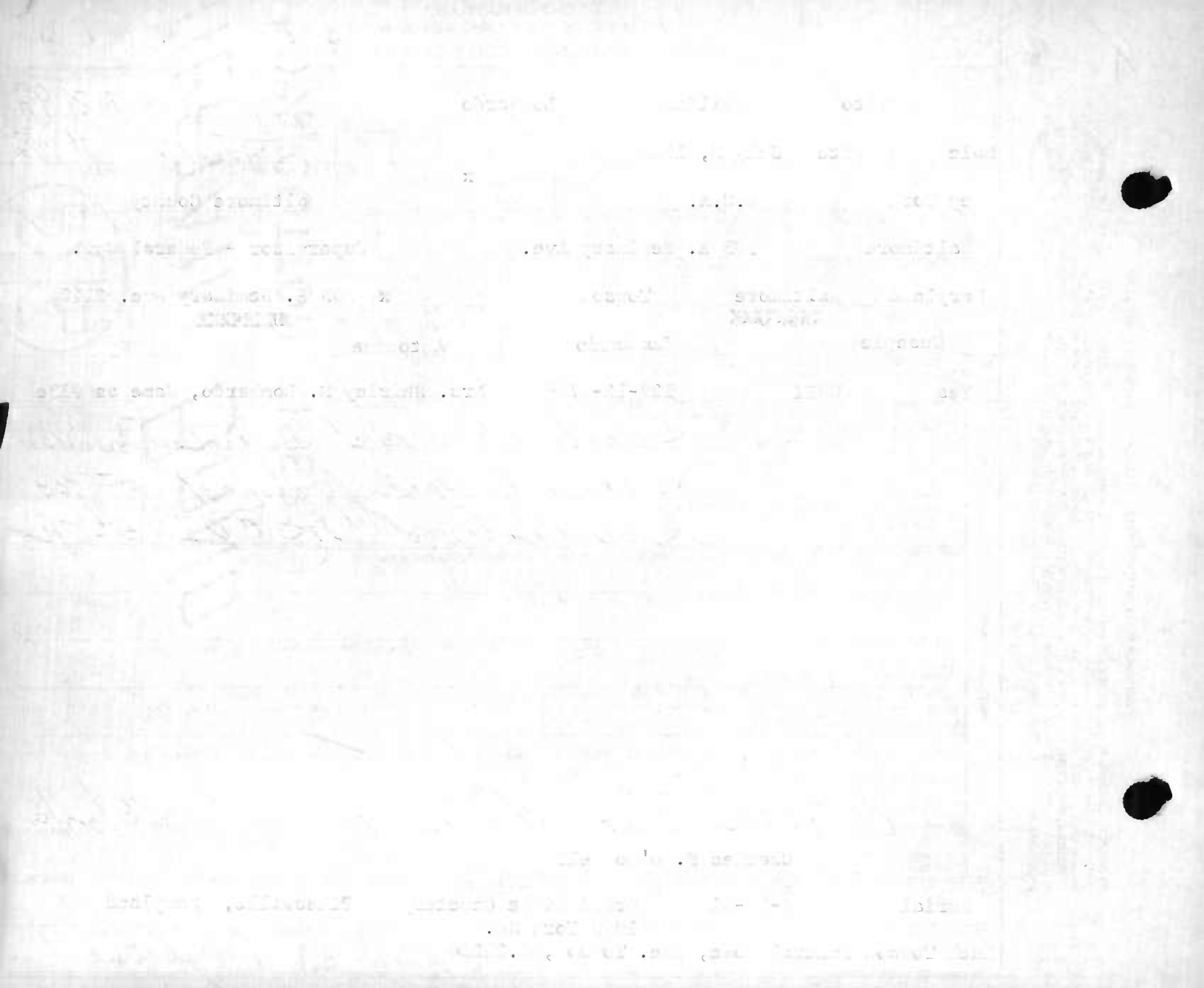
ORIGINAL FILED

REPORT-ATTENDING PHYSICIAN, MD.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14770					
1. DECEASED NAME (TYPE OR PRINT) <b>Vito William Lombardo</b>						2a. DATE KNOWN OF ESTI. DEATH <b>June 27, 1981</b>		2b. HOUR <b>9:00 AM</b>		2c. DATE PRONOUNCED DEAD <b>June 27, 1981</b>		2d. HOUR <b>3:00 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 5, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>June 27, 1981</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>503 E. Seminary Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor - Federal Gov.</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>503 E. Seminary Ave. 21204</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gusepie Lombardo</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Antonina</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				(IF YES, GIVE WAR OR DATES) <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>129-12-6756</b>		17. INFORMANT ADDRESS <b>Mrs. Shirley M. Lombardo, Same as #13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized ASCVD</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>5± yrs</b> <b>5± yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a.															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>6/27/81</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell</b>				ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>6-30-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b> ADDRESS <b>Towson, Md. 21204</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>				25b. REGISTRAR'S SIGNATURE <b>Shirley M. Lombardo</b>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8114771							
1. DECEASED NAME (TYPE OR PRINT) <b>Genevieve V. Lusk</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>June 26, 1981</b>			2b. HOUR M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 5, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2401 Taylor Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2401 Taylor Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lundy Milton Miller</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucy Mae McMillion</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>234-28-5133</b>		17. INFORMANT <b>Mr. John W. Lusk,</b>		ADDRESS <b>same as #13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Pulmonary Emphysema.</b> <b>4920</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a: _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>7/17</b> 19 <b>75</b> to <b>6/4</b> 19 <b>81</b> that (1) <input checked="" type="checkbox"/> last saw the deceased alive on <b>6/4</b> 19 <b>81</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (2) <input type="checkbox"/> did not view the body after death.									
22b. SIGNATURE <b>Ruben S. Sebastian</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/26/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ruben S. Sebastian, M.D.</b>				22e. ADDRESS <b>2314 E. Joppa Rd.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 29, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J. Ruck, Inc. 5305 Harford Rd. Balto. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Letsy McBrady</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## STATE OF MARYLAND

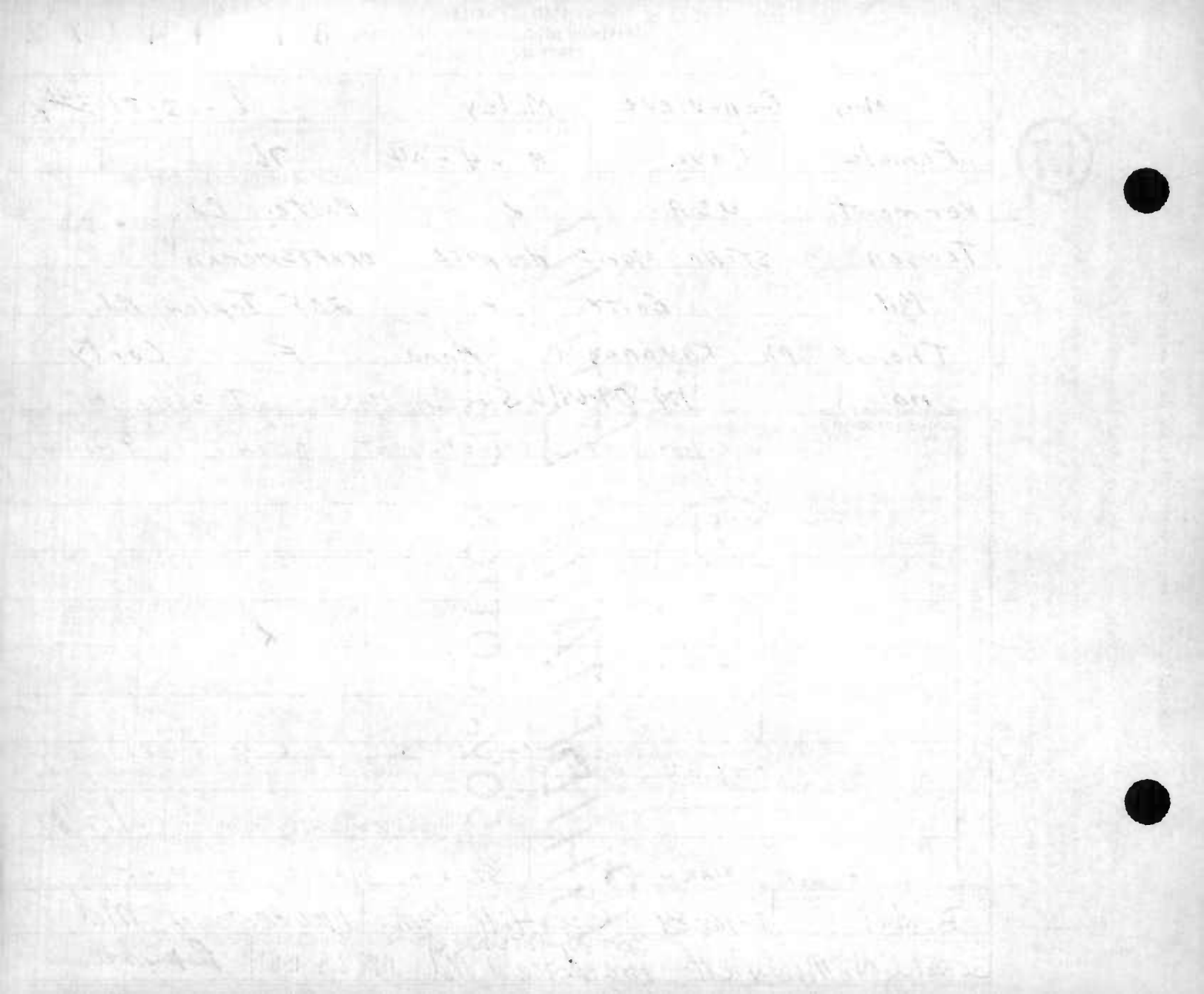
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8114772

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Genevieve Maley</b>			2a. DATE OF DEATH MONTH <b>6</b> DAY <b>13</b> YEAR <b>81</b> 2b. HOUR <b>3:40</b> P.M.		
3. SEX <b>Female</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH <b>9</b> DAY <b>4</b> YEAR <b>04</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.		
10. CITY OR TOWN OF DEATH <b>Towson</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS Hospice</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>DRAFTSWOMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MD.</b>		13b. COUNTY	13c. CITY OR TOWN <b>Balto.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Thomas M.</b> MIDDLE <b>Kavanagh</b> LAST <b>Anna</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Anna</b> MIDDLE <b>F.</b> LAST <b>Carty</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>179-09-6466</b>		17. INFORMANT ADDRESS <b>STELLA MARIS - TOWSON MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1991 METASTATIC MALIGNANT DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 23, 19 81</b> , to <b>JUNE 13, 19 81</b> , that (I) (we) lost saw the deceased alive on <b>MAY 29, 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE		22c. DATE SIGNED <b>6/13/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. EDDIE NAKHUDA</b>		22e. ADDRESS <b>STELLA MARIS HOSPICE</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>	23b. DATE <b>6-16-81</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Hagerstown, Md</b> COUNTY <b>Md</b> STATE	
24. FUNERAL DIRECTOR NAME <b>Serald N. Minnick</b> ADDRESS <b>305 N. Potomac St. Hagerstown, Md</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 25 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8114773	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
ESTHER Marie MANDLER					June 6, 1981					2:18 a.m.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH 06 DAY 25 YEAR 1916		64 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Rossville		Franklin Square Hospital								Housewife	
12b. KIND OF BUSINESS OR INDUSTRY		Homemaking									
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland					Baltimore		Overlea		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
John Calvin Andrews					Alice Emerson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					214-12-9404		Charles F. Mandler 4014 Marjeff Place				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Complicating Congestive Heart</u> (b) <u>Failure with Chronic Atrial Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 5, 1981, to June 6, 1981, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on June 6, 1981, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE				DEGREE				22c. DATE SIGNED			
								June 6, 1981			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
H. Hernandez M.D.				9000 Franklin Square Drive 21237							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6/9/81		Parkwood Cemetery		Parkville Baltimore Md.					
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REG'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Lassan Funeral Home 7701 Belair				JUN 12 1981							



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 1 1 4 7 7 4

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELLSWORTH L MANN			6 20 81			M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 12 27		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore COUNTY MD.			
10. CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST JOSEPH'S HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Letter Carrier		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6504 Hilltop Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Theodore Mann				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie ? J					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 214-24-3378		17. INFORMANT Mrs Mary E Mann		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>As it is</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour. 4 years.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE E. Bevel			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. F. HUANG, M.D.			22e. ADDRESS 2401 OSCAR DRIVE ZIMMERMAN						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/23/81		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland					25a. DATE REC'D. BY REGISTRAR JUN 22 1981		25b. REGISTRAR'S SIGNATURE L. F. HUANG		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the health officer, death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 81 14775				
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Florence Marcus					2a. DATE OF DEATH MONTH DAY YEAR 6 12 81				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 27 97		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7b. HOUR 600 A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH County BALTO. MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sewish Conv. and Nurs.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY BALTO. 13c. CITY OR TOWN BALTIMORE					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS APT. 912 5715 PARK HTS. AVE. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST GERSHON COHEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 218-26719		17. INFORMANT MRS. A. J. WOLF 8204 CRANWOOD CT. BALTO., MD 21208		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bowel 1590 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/7/81, 19 81, to 6/12/81, 19 81, that (I) (we) lost saw the deceased alive on 6/12/81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Dr. Collier					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Collier					22e. ADDRESS 600 REISTERSTOWN RD. BALTO., MD 21208				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/14/81		23c. NAME OF CEMETERY OR CREMATORY TZEMECH SEDEK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					25a. DATE REC'D. BY REGISTRAR JUN 17 1981		25b. REGISTRAR'S SIGNATURE J. F. H. H. H.		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE M. MARINO</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>6 . 27 . 81</b> 2b. HOUR <b>5:30 AM</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 11 31</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>49</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Lansdowne</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2523 Gehb Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Manf. Co.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Lansdowne</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2523 Gehb Avenue Balto., Md.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Harry Helwig</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>May Wagener</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>216-28-3414</b>		17. INFORMANT ADDRESS <b>21227 Sam C. Marino 2523 Gehb Avenue Balto., Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b> 1991 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } <b>METASTATIC CARCINOMA</b> (b) } (c) }									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) (hospital) attended the deceased from <b>4 . 25 . 81</b> , to <b>6 . 27 . 81</b> , that (we) last saw the deceased alive on <b>6 . 26 . 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Keith Falcao</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6.27.81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KEITH FALCAO</b>		22e. ADDRESS <b>3350 WILKENS AVE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/30/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard Co. Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Hubbard Funeral Home, Inc.</b>		BALTO., MD. 21229 ADDRESS <b>4107 Wilkens Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 29 1981</b>		25b. REGISTRAR'S SIGNATURE <b>P. J. H. H. H.</b>			

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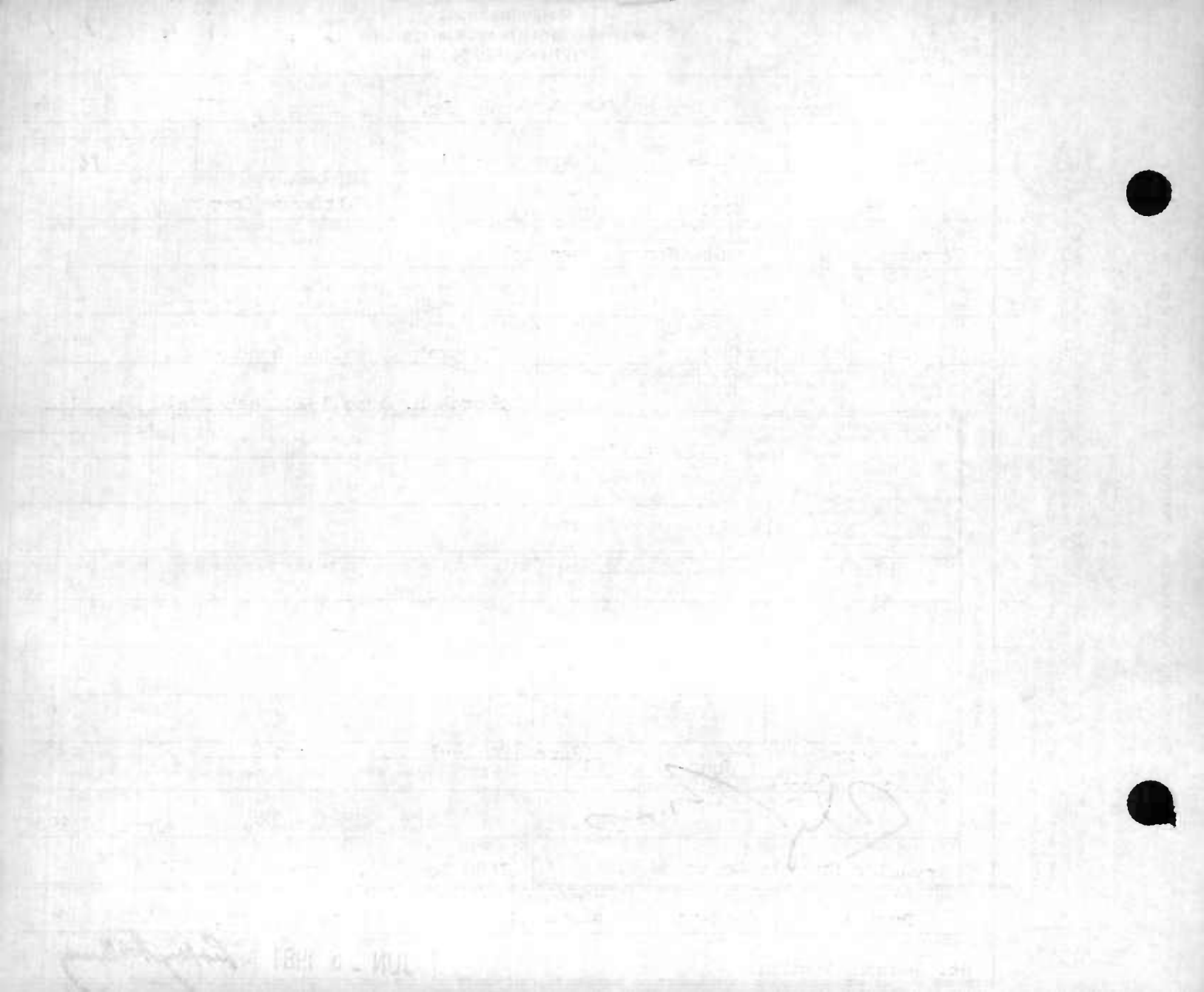


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE														
CERTIFICATE OF DEATH														
REG. NO.														
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					June 9, 1981					11:24 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
Male		White		June 9, 1981						10				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
Md.		U.S.A.				Baltimore County MD.								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Towson		St. Joseph Hospital												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		
13a. STATE Md.										13b. COUNTY Balto.		13c. CITY OR TOWN Balto.		1920 East Field Rd.
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Steven Derek Marsh					Deborah Helen Agee									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
							Deborah H. Agee, 1920 East Field Rd. 21222							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) <u>Immaturity</u>														
7651 DUE TO, OR AS A CONSEQUENCE OF (b)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (X) (this hospital) attended the deceased from June 9, 1981, to June 9, 1981, that X (we) lost saw the deceased alive on June 9, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)														
22b. SIGNATURE DEGREE								22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS						
Reynaldo Orjuela-Gomez, M.D.								7620 York Rd. Towson, Md. 21204						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial			6-16-81		Parkwood			Balto., Md.						
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
St. Joseph Hospital						JUN 15 1981		[Signature]						







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Marion Grachian Marshall</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 5, 1981</b>			2b. HOUR <b>7:56 A</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 21 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Josephs Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Service Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Rittenhouse</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Glen Arm</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>11437 Long Green Pike 21057</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Albert Marshall</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cora Ward</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-05-1689</b>		17. INFORMANT ADDRESS <b>1700 Valley Brook Drive Kingsville, Md. 21087</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD - ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b> <b>YEARS</b> <b>YEARS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (X) (this hospital) attended the deceased from <b>May 29,</b> 19 <b>81</b> , to <b>June 5,</b> 19 <b>81</b> , that (we) last saw the deceased alive on <b>June 5,</b> 19 <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)											
22b. SIGNATURE <b>W. Hernandez</b>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W. Hernandez M.D.</b>						22e. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>6/8/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore</b>			
24. FUNERAL DIRECTOR NAME <b>E.F. LASSAHN F.X.</b>						ADDRESS <b>11750 Belair Rd.</b>			25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>		
						25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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June 2, 1981

Station 1000



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secondary forest

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from

June 2, 1981

June 2, 1981

1:50 from 1000, Towson, Md. 21501

Station 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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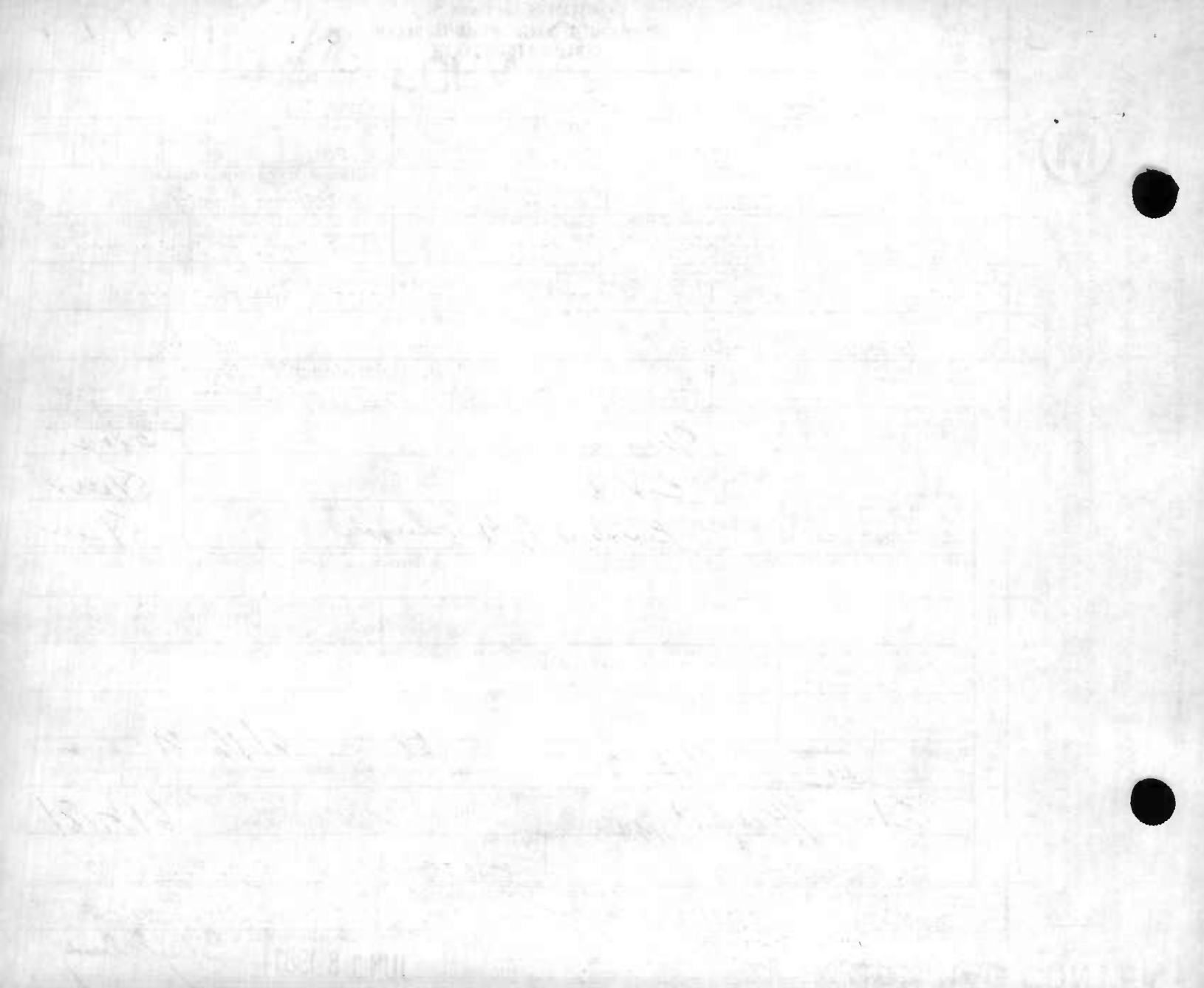
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
1. FOR STATE REGISTRAR					REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Mrs. Mary Agnes Mathews</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>June 16, 1981</i>					2b. HOUR <i>M</i>				
3. SEX <i>Female</i>			4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 26, 1882</i>			6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>99</i>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>New York</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.						
10. CITY OR TOWN OF DEATH <i>Randallstown</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3405 Offutt Road 21133</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk-Dept. of Agriculture</i>			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13b. STREET ADDRESS <i>3405 Offutt Road 21133</i>				
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Randallstown</i>									
14. FATHER'S NAME FIRST MIDDLE LAST <i>Andrew Maczulonis</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Agnes Unknown</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO <i>213-74-0273</i>		17. INFORMANT ADDRESS <i>Mr. John Joseph Mathews 3405 Offutt Road Randallstown, MD. 21133</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic -</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>C.I.A.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <i>Renalized Arteriosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>5 years</i> <i>5 years</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>6/13/81</i> 19 <i>81</i> , to <i>6/16/81</i> 19 <i>81</i> , that (I) (we) lost <i>saw the deceased</i> on <i>6/13/81</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (not) view the body after death.														
22b. SIGNATURE <i>Edwin Pierpont, M.D.</i>					DEGREE					22c. DATE SIGNED <i>6/16/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Edwin Pierpont</i>					22e. ADDRESS <i>8204 Liberty Road Balto. MD. 21207</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>					23b. DATE <i>6/19/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i>				
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, P.A.</i>					25. DATE REC'D. BY REGISTRAR <i>JUN 18 1981</i>					26. REGISTRAR'S SIGNATURE <i>Loring Byers</i>				
27. ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 1 1 4 7 8 0				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
SYLVIA. G. MAZER					MONTH DAY YEAR 06 09 81				
3 SEX FEMALE					2b. HOUR 5 35 A.M.				
4 RACE WHITE					5. DATE OF BIRTH				
					MONTH DAY YEAR 01 04 16				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS				
7b. CITIZEN OF WHAT COUNTRY? USA					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH RANDALLSTOWN					9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BALTIMORE COUNTY GEN. HOSP.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				
					12b. KIND OF BUSINESS OR INDUSTRY AT HOME				
13a. STATE MARYLAND					13b. CITY OR TOWN BALTO.				
					13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT COHEN					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER DILLER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 218-46-4157				
					17. INFORMANT ADDRESS AARON MAZER 7908 DUNHILL VILLAGE CIR., APT. 102 BALTO., MD 21207				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) 1539 CANCER COLON & METASTASIS									
DUE TO, OR AS A CONSEQUENCE OF (b) -									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (c) -									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK									
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)									
21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 6-8-1981 to 6-9-1981, that (I) (we) last saw the deceased alive on 6-9-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE									
22c. DATE SIGNED 6/9/81									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. SUDHIR D. PATEL									
22e. ADDRESS BAL. COUNTY GEN. HOSPITAL									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL									
23b. DATE 6/10/81									
23c. NAME OF CEMETERY OR CREMATORY CHIZUK AMONO									
23d. LOCATION BALTIMORE COUNTY MARYLAND									
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215									
25a. DATE REC'D. BY REGISTRAR JUN 17 1981									
25b. REGISTRAR'S SIGNATURE [Signature]									

BP



IND

MAINTENANCE

NOTION 3000

Handwritten signature or initials.

1981 7 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OSCAR P McCAULEY</b>				6-29-81 1205 A.M.			
3 SEX <b>Male</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10-25-97</b>		6. AGE (IN YEARS, LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>84 83 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT, BUSCH FACILITY, GIVE STREET ADDRESS) <b>PERRY PARK NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Glazier</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN <b>Maryland Baltimore Perry Hall</b>				13e. STREET ADDRESS <b>3825 E. Joppa Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Parris E McCauley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>Ada Marshall</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>212-01-4258</b>		17. INFORMANT ADDRESS <b>Mrs Mary Ellen McCauley Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Terminal CA Lung Metastasis</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on <b>6/4</b> 19 <b>81</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death.							
22b. SIGNATURE <b>Celair Parra</b>				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Celair Parra M.D.</b>				22e. ADDRESS <b>7122 Harford Rd Baltimore, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>7/2/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25a. DATE REC'D. BY REGISTRAR (SIGNATURE) <b>JUL 1 1981</b>			



212-01-4258 Mrs Mary Ellen McCauley Same  
Paris E McCauley Ada Marshall  
Maryland Baltimore Perry Hall xx 3825 E. Jopba Rd

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 8 2

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROSE LEONARD McCLAFFERTY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 22, 1981</b>			2b. HOUR <b>8:30</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 30, 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Conn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Towson</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Michael Leonard</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate Hogan</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>041-58-2988</b>		17. INFORMANT <b>5 Theo Lane, Towson, Md. 21204</b> <b>Dr. William J. McClafferty,</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Organic Brain Syndrome, Atherosclerotic Cardiovascular Disease.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JUN 22 19 81</b> to <b>JUNE 22 19 81</b> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <b>JUNE 22 19 81</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If <input type="checkbox"/> did not view the body after death.)							
22b. SIGNATURE <b>J. Nelson McKay</b>				22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>6/23/81</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. J. Nelson McKay</b>				22f. ADDRESS <b>1132 N. Rolling Rd., Catonsville, Md. 21228</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Norwich, Conn.</b>	
24. FUNERAL DIRECTOR NAME <b>1630 Edmondson Ave., Catonsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Witzke Catonsville Funeral Home, P.A. 21228</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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June 20, 1900

Washington

Howard

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Dec. 30, 1899

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St. Joseph's Hospital

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St. Joseph's Hospital

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St. Joseph's Hospital

St. Joseph's Hospital

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Baby Girl, McClaskey

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours after death. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M  
(VR A15 (4))STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 4 7 8 3

1. DECEASED-NAME (Type or print) <b>Baby girl</b>			First Middle Last <b>McClaskey</b>			2a. DATE OF DEATH Month Day Year <b>June 15, 1981</b>			2b. HOUR <b>3:30 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>June 15, 1981 1:41pm</b>			6. AGE (In years last birthday) <b>YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>1 4</b>		IF UNDER 24 HRS. HOURS MIN. <b>30 00</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Baltimore County</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Towson</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>St. Joseph Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>479 Langley Rd 21221</b>		
14. FATHER'S NAME First Middle Last <b>David D McClaskey</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Tracey Rayl</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST.</b> <b>7400</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ANENCEPHALY AND. OMPHALOCOELE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>AND. PREMATUREITY.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>NO SPONTANEOUS RESPIRATION</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State <b>(2130pm to 3:30pm)</b>								
22a. I certify that <b>He</b> (this hospital) attended the deceased from <b>6-15-1981</b> , to <b>6-15-1981</b> , that <b>He</b> (we) last saw the deceased alive on <b>6-15</b> 19 <b>81</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>He</b> (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Pornswan</b>			22c. DATE SIGNED <b>6-15-81</b>			22d. PHYSICIAN'S NAME (Type) <b>PORN SWAN</b>								
22e. ADDRESS <b>WASANT MD.</b>			22f. ADDRESS <b>ST. JOSEPH HOSPITAL.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>June 17, 1981</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>			23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>St. Joseph Hospital</b>						25a. REC'D BY REGISTRAR DATE <b>JUN 25 1981</b>			25b. REGISTRAR'S SIGNATURE <b>Notary Public</b>					

Post Office, Philadelphia

PAID

NOTICE

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 8 4

1- FOR  
STATE  
REGISTRAR

REG. NO.

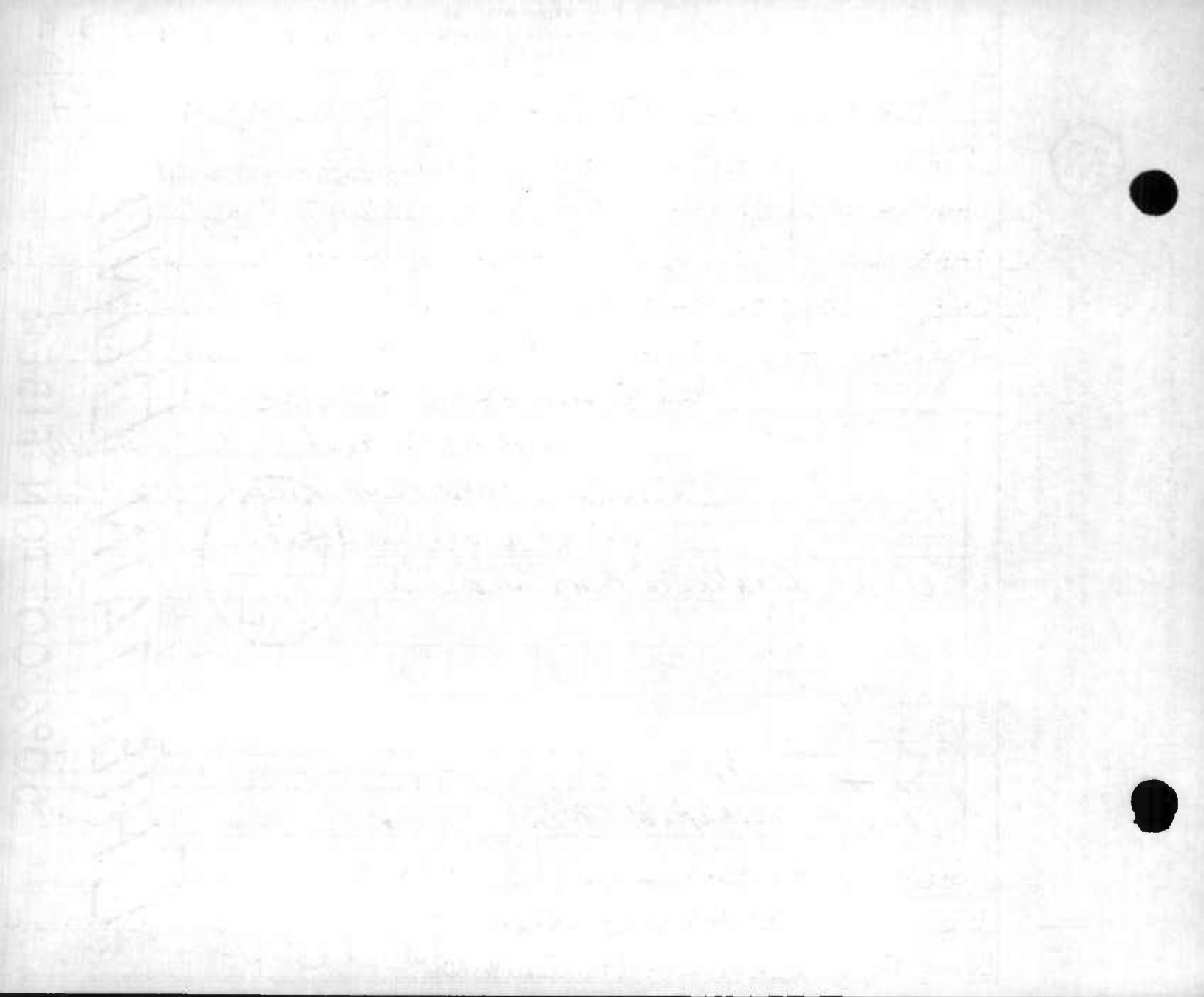
1. DECEASED NAME (TYPE OR PRINT) <b>MARTIN L. McCLARY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 21 1981</b>			2b. HOUR <b>5A M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUGUST 12 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>PARKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8517 FOWLER AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HIGHWAYS</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE OF MD.</b>	
13a. STATE <b>MO.</b>				13b. CITY OR TOWN <b>PARKVILLE</b>		13c. STREET ADDRESS <b>8517 FOWLER AVE.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOSEPH A. McCLARY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET C. LEOYEN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>220 204477</b>		17. INFORMANT ADDRESS <b>FAMILY RECORDS</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac Arrest</b> <b>4255</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Alcoholic Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>incipient Liver Cirrhosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instantly</b> <b>3 yrs.</b> <b>3 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Alcoholic Brain Syndrome</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>JUNE 13</b> , 19 <b>76</b> , to <b>JUNE 21</b> 19 <b>81</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>6/13</b> , 19 <b>81</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> did not view the body after death.									
22b. SIGNATURE <b>John H. Hirschfeld M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>6/23/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John H. HIRSCHFELD</b>						22e. ADDRESS <b>6919 HARFORD ROAD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>6-24-1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LAKEVIEW M-PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARYLAND</b>		
24. FUNERAL DIRECTOR NAME <b>EVANS FUNERAL CHAPEL</b>						ADDRESS <b>8300 HARFORD ROAD</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1981</b>	
						25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	1	4	7	8	5
FOR 1 - STATE REGISTRAR										CERTIFICATE OF DEATH						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH						
EDITH May MCCOSKREY										June 11, 81						
3. SEX Female										2b. HOUR 2:40 AM						
4. RACE Cauc.										6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS						
5. DATE OF BIRTH MONTH DAY YEAR 11 29 1896										8. AGE (IN YEARS LAST BIRTHDAY) 84 YRS						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD						
7b. CITIZEN OF WHAT COUNTRY? U.S.A.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerical worker U.S. Gov't						
10. CITY OR TOWN OF DEATH Randallstown										12b. KIND OF BUSINESS OR INDUSTRY						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Balto. County General Hospital										12c. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland										13b. STREET ADDRESS 7 Red Mare Court #21030						
13c. COUNTY Balto.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13e. CITY OR TOWN Cockeysville										13f. STREET ADDRESS						
14. FATHER'S NAME FIRST MIDDLE LAST Charles ----- Cutsail										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine ----- Moberly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no --										16b. SOCIAL SECURITY NO. 216-10-91204						
17. INFORMANT Elaine Larkin, 10628 Partridge Lane										ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-respiratory arrest 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral-vascular accident DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus.																
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)																
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE																
22a. I certify that (I) (this hospital) attended the deceased from May 21, 1981 to June 11, 1981, that (I) (we) lost saw the deceased alive on June 11, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Ghassem Pourmotabbed, M.D.										22c. DATE SIGNED 6-11-81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GHASSEM POURMOTABBED										22e. ADDRESS Balto. County Gen. Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 6/13/81						
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery										23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Balto. Maryland						
24. FUNERAL DIRECTOR J. E. Lowell Lemmon										25a. DATE REC'D. BY REGISTRAR JUN 15 1981						
25b. REGISTRAR'S SIGNATURE [Signature]																

BP



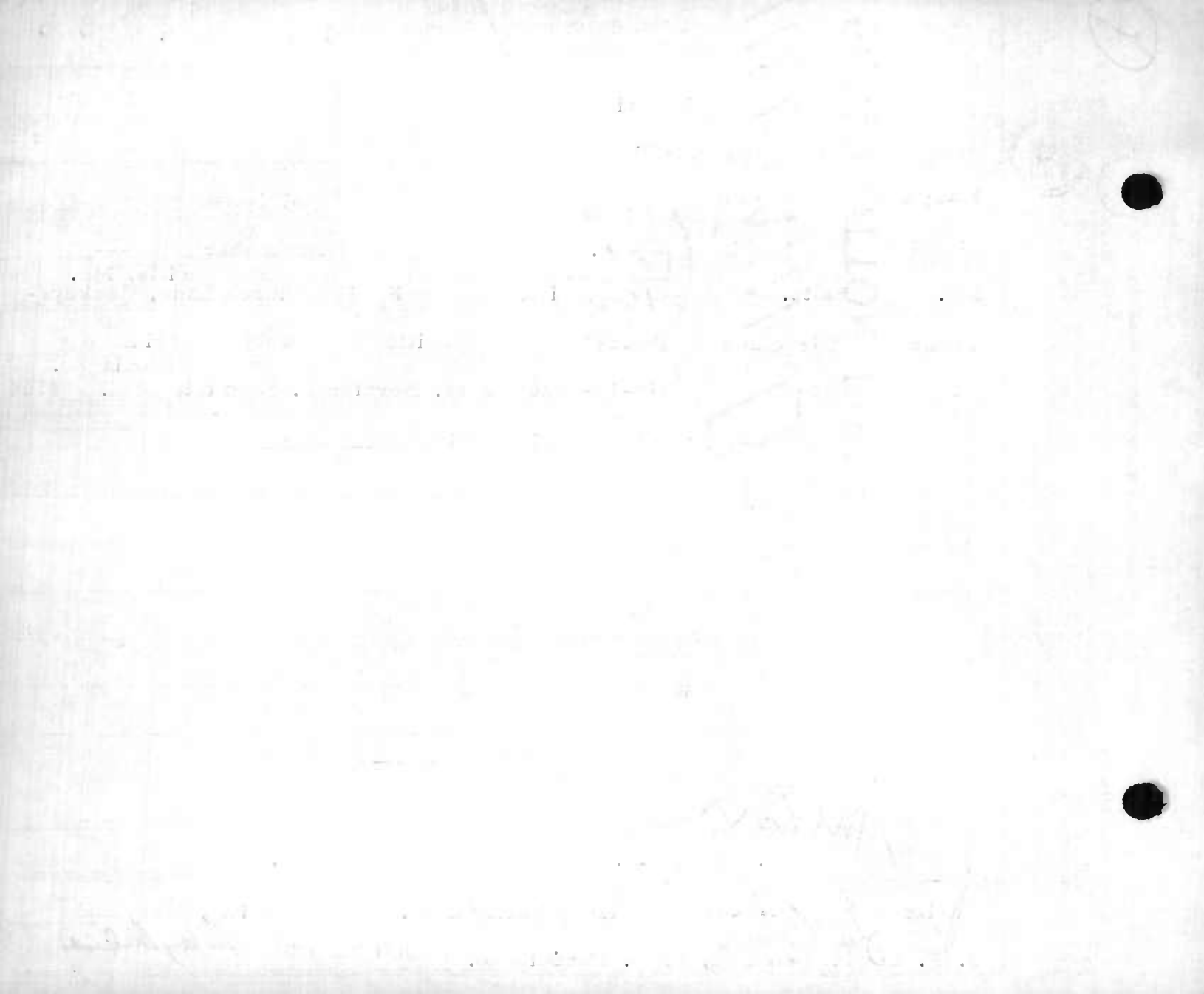
*[Faint, mostly illegible text and markings covering the page, possibly bleed-through from the reverse side.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VRA15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14786	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERNICE Eldoris MC DERMOTT										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <input checked="" type="checkbox"/> 6 6 19 81	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR June 9, 1920		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 60 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 6 19 81		2b. HOUR 5:35 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County				10. CITY OR TOWN OF DEATH Timonium				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 74 Padonia Rd.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				12b. KIND OF BUSINESS OR INDUSTRY ---				13a. STREET ADDRESS ville, Md. 129 Church Lane, Cockeys-			
13b. STATE Md.				13c. CITY OR TOWN Cockeysville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Cleveland Dowdy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucille Frances Skimore				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No No			
16b. SOCIAL SECURITY NO. 214-12-9686				17. INFORMANT Mrs. Bernice B. Schmidt, 74 E. #104				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER	
ACTUAL SIGNATURE Ann M. Dixon, M.D.				DATE SIGNED 6-7-81							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-10-81				23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cem.			
23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville, Maryland				24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon				25a. DATE REC'D. BY REGISTRAR JUN 9 - 1981			
25b. REGISTRAR'S SIGNATURE L. J. McPherson											

MEDICAL CERTIFICATION

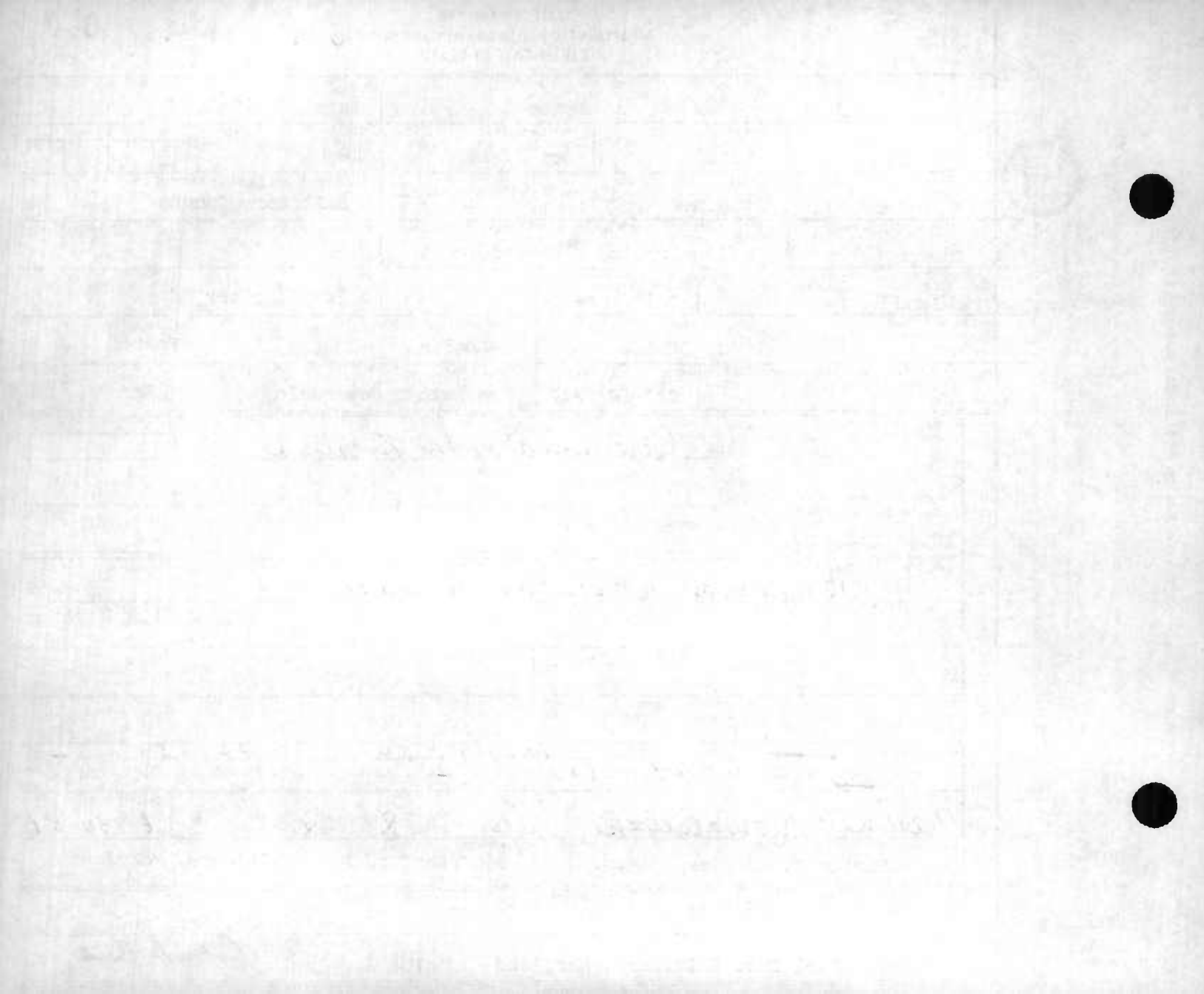


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Dora E McGee					June 26, 1981				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Oct 2, 1884		96		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Baltimore County MD.			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY	
Towson		Valley Nursing & Convalescent				Housewife			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		17. CITY OR TOWN		18. INSIDE CITY LIMITS?		19. STREET ADDRESS			
Maryland		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1407 Lochner Rd			
20. FATHER'S NAME		21. MOTHER'S MAIDEN NAME							
? Fehete		Amelia Fehete							
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		23. SOCIAL SECURITY NO.		24. INFORMANT		25. ADDRESS			
No		213-50-2717		Mrs Ruth M Coverdale		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1541 IMMEDIATE CAUSE (a) Carcinoma of the Rectum									
DUE TO, OR AS A CONSEQUENCE OF (b)									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Peripheral vascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (the hospital) attended the deceased from December 19 80, to 6-26 19 81, that (I) (we) lost saw the deceased alive on 6-24 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) (did not) view the body after death.									
22b. SIGNATURE				DEGREE		22c. DATE SIGNED			
Marion C. Kowalewski				M.D.		6-30-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Marion C. Kowalewski M.D.				8604 Harford Rd Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		6/30/81		Holy Redeemer		Baltimore, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leonard J Ruck Inc. Baltimore, Maryland				JUL 1 1981		P. J. McCready			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 8 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marjorie Anne McKee</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>June 7, 1981</b>		2b. HOUR <b>5 a.m.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 21, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Reisterstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>110 Butler Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Md.</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Reisterstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Charles Brooks</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nancy Eleanor Mayes</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-48-7287</b>		17. INFORMANT <b>Donald H. Wilson</b> ADDRESS <b>14 Glyndon Ave., Glyndon, Maryland 21071</b>	
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>May 15, 1981</b> to <b>June 7, 1981</b> , that (I) (we) lost saw the deceased alive on <b>May 27, 1981</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. E. McWilliams MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>June 8, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. E. McWilliams MD</b>		22e. ADDRESS <b>11904 Reisterstown Rd. Reisterstown Md. 21136</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 9, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessops Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY <b>Sparks Balto., Maryland</b>		23e. DATE <b>JUN 10 1981</b>		23f. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR NAME <b>H. J. Ehlhardt</b>		ADDRESS <b>Owings Mills, Md.</b>		25a. DATE <b>JUN 10 1981</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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MAILED

MAILED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8114789	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Marie HARRIET McKim			7a. DATE OF DEATH MONTH DAY YEAR 6/16/81		7b. HOUR 12:23AM	
3. SEX F	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12/02/05	6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH Randallstown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD.	13b. COUNTY BALTO	13c. CITY OR TOWN Pikesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 9 Church Ln. 21208		
14. FATHER'S NAME FIRST MIDDLE LAST ELMER J. PREBLE	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE HALLIGAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	16b. SOCIAL SECURITY NO. 213-05-4542	17. INFORMANT JOAN HEIN		ADDRESS 4813 CROWSON AVE 21212		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE MYOCARDIAL INFARCTION</u> 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> (c) <u>DIABETES MELLITUS</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>5-13</u> , 19 <u>81</u> , to <u>6-15</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>5-13</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did not) view the body after death.)						
22b. SIGNATURE Samuel P. Scakia, MD.				22c. DATE SIGNED 6-16-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL P. SCAKIA, MD.				22e. ADDRESS 7 Church Lane BALTO. MD. 21208		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) ENTOMBMENT		23b. DATE 6-19-81	23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville MD.	
24. FUNERAL DIRECTOR NAME NEWELL F.H.		24b. ADDRESS Pikesville, MD.		25. DATE REG'D. BY REGISTRAR JUN 20 1981		
25b. REGISTRAR'S SIGNATURE						

BP

THURSDAY

1901

1901

MD BALTO. EXCHANGE

ELMER D. FRETZ KATHOLIC

NO. 101-102-103 HAN AND CROSBY ST.

101-102-103 HAN AND CROSBY ST.

101-102-103 HAN AND CROSBY ST.

101-102-103 HAN AND CROSBY ST.

101-102-103 HAN AND CROSBY ST.

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101-102-103 HAN AND CROSBY ST.

101-102-103 HAN AND CROSBY ST.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 9 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOHN J. McSTRAVICK			2a. DATE OF DEATH MONTH DAY YEAR JUNE 29 81			2b. HOUR M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR NOV 10 91		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD	
10. CITY OR TOWN OF DEATH CATONSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 625 ORPHINGTON RD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOLLER MAINT. B. GASTELLE	
13a. STATE MD				13b. COUNTY BALTO		13c. CITY OR TOWN CATONSVILLE	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES McSTRAVICK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN EDWARDS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W W 1 712-065438		17. INFORMANT ADDRESS JAMES McSTRAVICK 5903 POPE ST	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

IMMEDIATE CAUSE (a) Coronary thrombosis  
DUE TO, OR AS A CONSEQUENCE OF  
(b) Arteriosclerotic heart disease  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

Very short  
No. of years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>No injury</u>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/14/81</u> , 19 <u>81</u> , to <u>3/12/81</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>3/12/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>James P. Gundry</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>6/30/81</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>LEWIS GUNDRY MD</u>		22e. ADDRESS <u>21 Ruxview Ct. Puxton Md 21204</u>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 7-2-81		23c. NAME OF CEMETERY OR CREMATORY NEW CATHOLIC		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD	
24. FUNERAL DIRECTOR NAME <u>WEBER FUNERAL HOME</u>				ADDRESS <u>5311 Edmonstone</u>		25. DATE REC'D. BY REGISTRAR <u>JUL 6 1981</u>	
25b. REGISTRAR'S SIGNATURE <u>James P. Gundry</u>							



REG. NO.

DHMH - 16 50M 1/81  
(VRA 15, 4)

DHMH - 16 50M 1/81  
(VRA 15, 4)



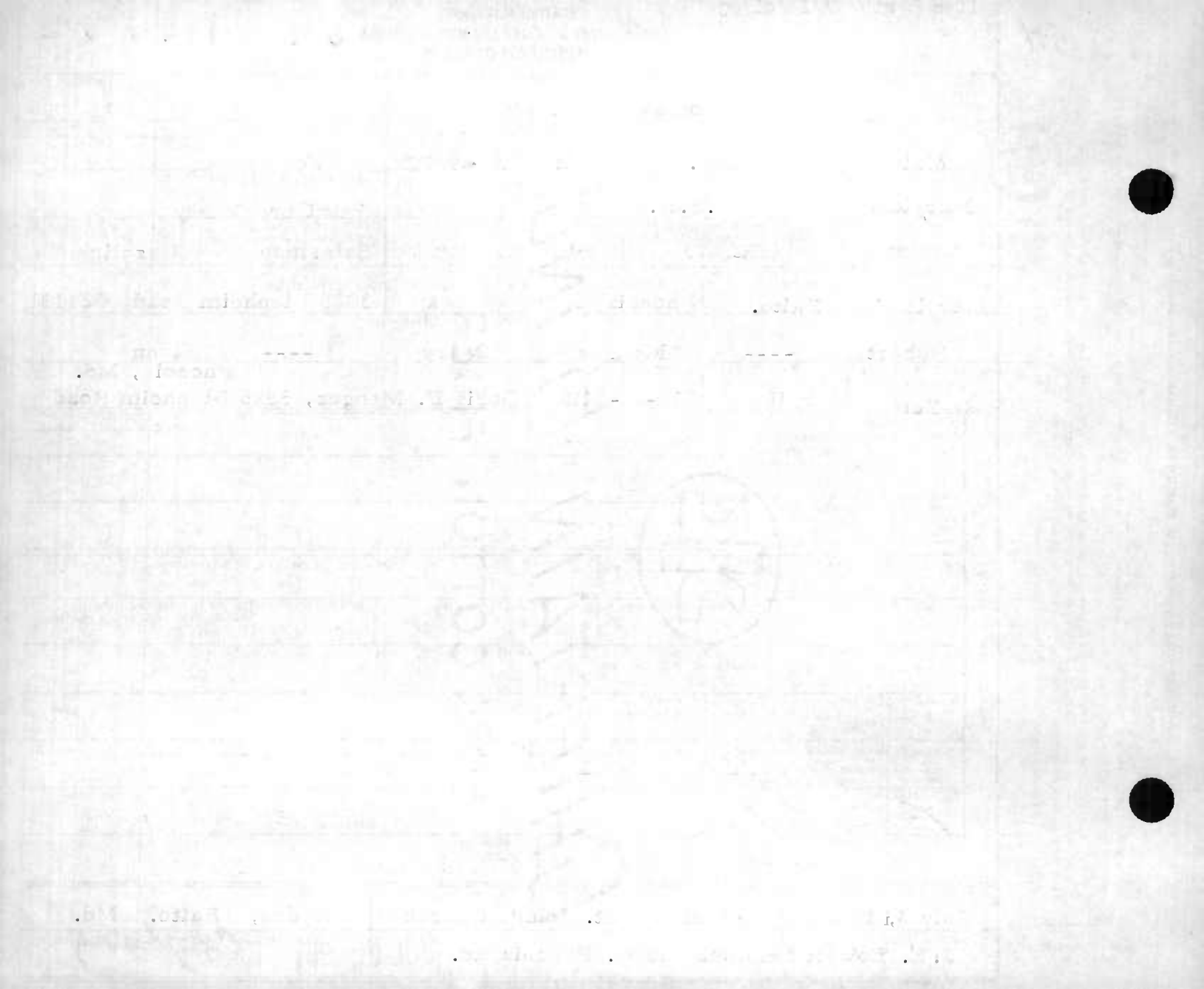


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at (410) 327-1234.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Hubert Thomas Menges					2a. DATE OF DEATH MONTH DAY YEAR 6 30 81				
3 SEX Male					2b. HOUR 12:15P M				
4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 11 16 1981			6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.		
10 CITY OR TOWN OF DEATH Towson		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GBMC 6701 N. Charles St. 21204			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Gasoline		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Balto.		13c. CITY OR TOWN Phoenix		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Hubert ----- Menges					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ----- Flynn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. WW II 215-01-5416		17. INFORMANT ADDRESS Doris P. Menges, 3825 Blenheim Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic CA</u> (c) <u>Small Cell CA of Lung</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/20</u> , 19 <u>81</u> , to <u>6/30</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Brian Adler					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 6/30/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Brian Adler, MD					22e. ADDRESS 6701 N. Charles St. 21204				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7/3/81		23c. NAME OF CEMETERY OR CREMATORY St. John's Church		23d. LOCATION CITY OR TOWN COUNTY STATE Hydes, Balto., Md.		
24. FUNERAL DIRECTOR (TYPE OR PRINT) J.E. Lowell Lemmon					25. DATE REC'D BY REGISTRAR JUL 02 1981		26. SIGNATURE OF REGISTRAR [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 1 4 7 9 3			
1. DECEASED NAME (TYPE OR PRINT) <b>George C. Mettee</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>June 25, 1981</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 1 1902</b>		2b. TIME OF DEATH HOUR MIN. <b>11:35 A.M.</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.		7. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Shoe Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dixon Bartlett Co.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>2802 Kentucky Ave.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Mettee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine Snyder</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-03-0708</b>	
17. INFORMANT ADDRESS <b>9129 Rexis Ave.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. <b>1560</b> IMMEDIATE CAUSE (a) <b>Cancer of the Gallbladder with</b> <b>Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>June 18, 1981</b> , to <b>June 25, 1981</b> , that (we) last saw the deceased alive on <b>June 25, 1981</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) <b>not</b> view the body after death.							
22b. SIGNATURE <b>Natividad D. de Leon, M.D.</b>		DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/25/81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Natividad DeLeon, M.D.</b>		22e. ADDRESS <b>7620 York Rd. Towson, Md. 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/27/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>	
24. FUNERAL HOME, ADDRESS <b>Schlimmek Funeral Home, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>				25a. DATE REC'D. BY REGISTRAR <b>JUN 26 1981</b>		25b. REGISTRAR'S SIGNATURE <b>L. J. [Signature]</b>	

12:00

June 22, 1981

Letter

C.

George

Baltimore County

St. Joseph Hospital

Townson

Center of the Cathedral

Harvest



June 22, 81

June 22, 81

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June 22, 81

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June 22, 81

81

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7000 York Rd., Towson, Md. 21204

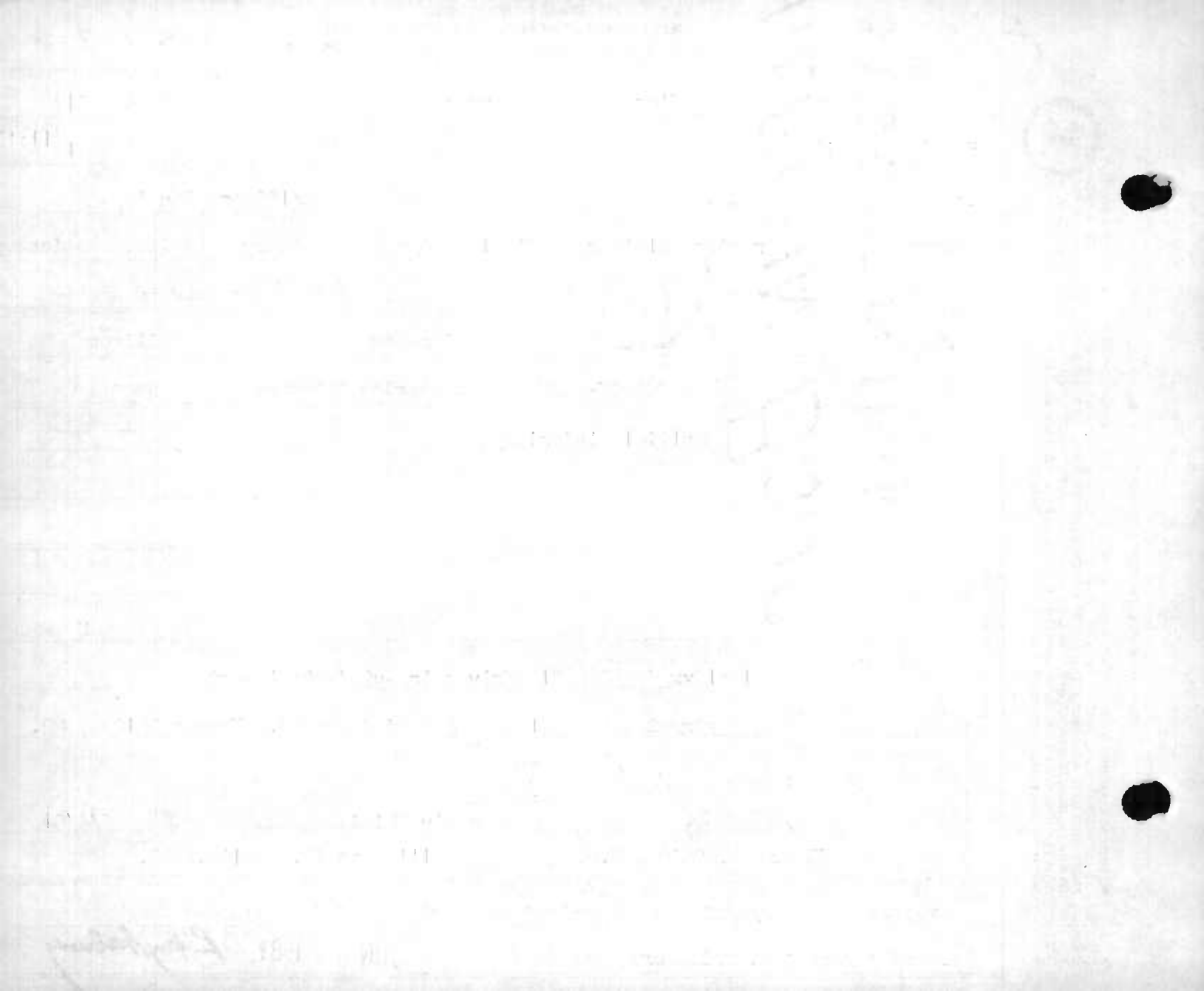
Rev. Richard Nelson, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 14794	
FOR 1- STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Flora Meurer										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 6 4 19 81	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 24, 1930		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 51		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 6 4 19 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.	
10. CITY OR TOWN OF DEATH Towson				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Baltimore Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept Manager Balto.		12b. KIND OF BUSINESS OR INDUSTRY Stationery	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Hillendale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1176 Pelhamwood Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Henry N Albers						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Rose Collison					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 217-24-6034		17. INFORMANT ADDRESS Mr Charles R Meurer Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:15xx 6 4 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) driver in auto/auto impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION CITY OR TOWN COUNTY STATE 1-695 east of Joppa Rd., Towson, Balto., MD.					
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 6/4/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6/8/81		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.						ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR JUN 5 - 1981		25b. REGISTRAR'S SIGNATURE L. J. Ruck	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 1 1 4 7 9 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Mildred I. MEYER			June 9, 1981			12:50 A		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	April 7, 1907	74			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						
Ohio	USA	9. BALTIMORE CITY OR COUNTY OF DEATH						
		Baltimore County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Rossville	Franklin Square Hospital		Teacher			Balto. County		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS		
Maryland			Baltimore			Essex		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		
Henry Shramm			Catherine Gross			No		
16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
215 42 7579			Frederick Meyer, husband			Same		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a) Respiratory Arrest

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Stroke

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from June 3, 1981, to June 9, 1981, that (we) lost saw the deceased alive on June 9, 1981, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>H. D.</i>				DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (USE PRINT)				22e. ADDRESS		6/9/81	
Humberto Hernandez, M.D.				9000 Franklin Sq. Drive		21237	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	6-11-81	Holly Hill Mem. Gardens	Baltimore County, Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Prudzinski Funeral Home		JUN 12 1981	
25b. REGISTRAR'S SIGNATURE			
<i>Prudzinski</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 127 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Funeral may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD F MICICHE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 21 1981</b>		2b. HOUR <b>6:14 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 29, 1911</b>		
6. AGE (IN YEARS-LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO, MD</b> MD.						
10. CITY OR TOWN OF DEATH <b>TOWSON MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Welder</b>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY		
13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1324 Meridene Dr</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Salvatore Miciche</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosalia Fertitta</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-12-9025</b>		17. INFORMANT ADDRESS <b>Mrs Helen I Miciche Same</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ACUTE MYOCARDIAL INFARCTION</b> (c) <b>CORONARY HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Coronary heart disease</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (if (this hospital) attended the deceased from <b>6/21/81</b> to <b>6/21/81</b> , that (we) last saw the deceased alive on <b>6/21/81</b> , and that it is (our) opinion death occurred on the date and hour and from the causes stated above (or we did not view the body after death).				
22b. SIGNATURE <b>Mark Skoplan MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>6/21/81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARK S. KAPLAN MD</b>		22e. ADDRESS <b>16918 York Rd Rockton Md 21111</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/24/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>		24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				
25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony R. Brady</b>				

6-147

JUNE 21 1901

WICHITA

RECEIVED



BALTIMORE CO. MD

ST. JOSEPH HOSPITAL

RECEIVED

CARDIOGENIC SHOCK

ACUTE MYOCARDIAL INFARCTION

CONCOMITANT HEART DISEASE

2028 COTTON FIBER

JUN 21 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Bertha Miller</b>			2a. DATE OF DEATH MONTH <b>June</b> DAY <b>2</b> YEAR <b>1981</b>			2b. HOUR <b>1.30</b> AM <input type="checkbox"/> PM <input type="checkbox"/>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>2/</b> DAY <b>21/</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. State</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>House Wife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Baltimore</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>505 N. Highland Ave., Baltimore, Md 21205</b>	
14. FATHER'S NAME FIRST <b>Kowalski</b> MIDDLE <b>Kowalski</b> LAST <b>Kowalski</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Marcjanna</b> MIDDLE <b>Marcjanna</b> LAST <b>Marcjanna</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>214-01-4196</b>		17. INFORMANT ADDRESS <b>1028 Hartmont Rd. Baltimore, Md. 21228</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolic</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arrhythmia Fibrillation</b> (apv.) (b) <b>Hypertensive Atherosclerotic Disease</b> ? DUE TO, OR AS A CONSEQUENCE OF <b>Organic Brain Syndrome</b> (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>November 12, 1979</b> , to <b>June 2, 1979</b> , that (I) (we) lost the deceased above on <b>March 19, 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>J. Nelson McKay M.D.</b> DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>JUNE 2, 1981</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. NELSON MCKAY M.D.</b>		22e. ADDRESS <b>1132 N. ROLLING Rd. Balto Md. 21228</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6-5-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GRACELAND CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD</b>	
24. FUNERAL DIRECTOR NAME <b>WEBER FUNERAL HOME</b> ADDRESS <b>5311 ELMWOOD AVE</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 4 - 1981</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia K. K... ..</b>			

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES  
DEPARTMENT OF CHEMISTRY  
CHICAGO, ILLINOIS 60637  
U.S.A.  
OFFICE OF THE DEAN  
1000 S. MICHIGAN AVE.  
CHICAGO, ILLINOIS 60605  
U.S.A.  
TELEPHONE (312) 937-1234  
FAX (312) 937-1234  
E-MAIL: dean@chem.uchicago.edu  
WWW: www.chem.uchicago.edu

CHIEF OF  
DEPARTMENT



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
FOR STATE REGISTRAR					8 1 1 4 / 9 8					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					
Lottie Miller					June 2, 1981					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
Female		White		April 21, 1902		79 YRS		A M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore County MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Hillendale		6620 English Oak Rd				Housewife				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland			Baltimore		Hillendale		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6620 English Oak Rd	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Greenbury W Burdette					Ida Madora Lewis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					213-14-9379		Mrs Eleanor L Owens 1334 Dartmouth Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary artery disease</u>										
4149										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes mellitus</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>81</u> , to <u>June 2</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>May 2</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22c. DATE SIGNED										
R. Donald Jandorf MD 6-3-81										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
R. Donald Jandorf MD					7403 Harford Rd. Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		6/5/81		Moreland Mem Park		Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
Leonard J. Ruck Inc. Baltimore, Maryland						JUN 4 - 1981 Rusty Hebrandy				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 7 9 9	
1 - FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST ROSE SELMA MILLER					MONTH DAY YEAR June 12, 1981					11:30a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		MONTH DAY YEAR 2 14 96		85 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia		U.S.A.				Baltimore County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rossville		Franklin Square Hospital				Retired		Housework			
13a. STATE					13b. CITY OR TOWN		13c. STREET ADDRESS				
Maryland					Baltimore		3321 Beech Avenue 21211				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST M Jacob Bloom					FIRST MIDDLE LAST Thelma Bloom						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					216-18-4519		Doris Sunderland 3321 Beech Avenue 21211				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulmonary Arrest; Congestive Heart Failure 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Antero-lateral Myocardial Infarction (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 9, 19 81, to June 12, 19 81, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on June 12, 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE					DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					22c. DATE SIGNED 6/12/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Irvin Cohen					22e. ADDRESS 9000 Franklin Square Drive 21237						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		6-15-81		Lorraine Park Cem.		Woodlawn, Balto. Co. Md.					
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
C.S. Zeiler & Son Inc. 6224 Eastern Ave. 21224					JUN 15 1981		Lillian Kebrudy				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 1 1 4 8 0 0	
1 - FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Anna</b> <b>XX</b> <b>M.</b> <b>MOONEY</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>June 15, 1981</b>		2b. HOUR <b>12:15A</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 3, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C &amp; P Telephone Co.</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>5 Hollis Court</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph J. Peroutka</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary B. Link</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-05-0110</b>		17. INFORMANT ADDRESS <b>Jo Anne M. Nasuta Same as #13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASCVD</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>year</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>6-10</b> , 19 <b>81</b> , to <b>6-15</b> , 19 <b>81</b> , that (I) (we) lost saw the deceased alive <b>6-14</b> , 19 <b>81</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Calvin Stoner</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-15-81</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Calvin Stoner</b>						22e. ADDRESS <b>714 York Rd. Towson 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>June 18, 1981</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>		ADDRESS <b>1050 York Road</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 17 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDMUND B MOORE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 15, 1981</b>			2b. HOUR P <b>8.10 P</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 24, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.		
10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SAINT JOSEPH HOSPITAL</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sheet Metal</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>Md</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edmund B. Moore Sr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Helen Miller</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 220 20 2456</b>		17. INFORMANT ADDRESS <b>Mary Helen Moore Same</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>C. Respiratory arrest</b> <b>1579</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of the pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 1/2 month</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION <b>4-13-81</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of pancreas - metastatic</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>P.M.</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>4-12-</b> 19 <b>81</b> , to <b>6-15-81</b> , 19 <b>81</b> , that (1) (we) lost saw the deceased alive on <b>6-14-81</b> , 19 <b>81</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.								
22b. SIGNATURE <b>Roberto Ferrer</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>6-15-81</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERTO D. FERRER, MD</b>				22e. ADDRESS <b>7600 Osler Ln MD 2120X</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6/16/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Weisburg Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Weisburg Balto. Co. Md</b>		
24. FUNERAL DIRECTOR NAME <b>Burgee Funeral Home</b>				24b. ADDRESS <b>3631 Falls Road 21211</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 22 1981</b>		
				25b. REGISTRAR'S SIGNATURE <b>Robert J. [Signature]</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Joseph Howard MOORE				June 3, 1981	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
MALE		WHITE		OCT. 1, 1902	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
MARYLAND		U. S. A.		78 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BALTIMORE		FRANKLIN SQUARE HOSPITAL		Baltimore County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TOBACCO FARMER		TENANT			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD.		BALTIMORE		BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
ZOLLIE -- MOORE		UNKNOWN		7837 BIRMINGHAM AVE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
UNKNOWN		217-36-9131		KATHLEEN L. MOORE-7837 BIRMINGHAM AVE BALTIMORE, MD 21234	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiopulmonary arrest; anterior myocardial infarction					
DUE TO, OR AS A CONSEQUENCE OF (b) Small cell carcinoma of lung					
DUE TO, OR AS A CONSEQUENCE OF (c) Acute bronchospasm					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (this hospital) attended the deceased from June 2, 19 81, to June 3, 19 81, that (we) lost the deceased alive on June 3, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Irving Cohen, MD		M.D.		June 3, 1981	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Irving Cohen, MD		9000 Franklin Square Dr., 21237			
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		6/6/81		EPIPHANY CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
FORESTVILLE (PR. GEO'S) MD.		JUN 16 1981			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
RICHARD A. COLEMAN-UPPER MARLBORO, MARYLAND 20870:		JUN 16 1981		R. A. Coleman	



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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

1982-1983

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8 1 1 4 8 0

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Isabelle Morgenstern</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>June 16, 1981</i>			2b. HOUR <i>3:00 AM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>December 26, 1921</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Woodlawn</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2010 GwynnOak Avenue</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home Maker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Woodlawn</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS <i>2010 Gwynn Oak Avenue</i>								
14. FATHER'S NAME FIRST MIDDLE LAST <i>Herbert Stewart Ebaugh</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Belle Mercer</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>220-20-3389</i>		17. INFORMANT ADDRESS <i>Mr. Carl Morgenstern, Sr. 2010 Gwynn Oak Avenue Balto. MD. 21207</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure - Thrombosis 1978 - on duty</i> <i>2500</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure - Hypertension 1969</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>536</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>9/13/80</i> to <i>6/16/81</i> , that (I) <del>was</del> lost saw the deceased alive on <i>9/13/80</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour, and from the causes stated above, (I) <del>well</del> (did not) view the body after death.								
22b. SIGNATURE <i>Edwin Pierpont, MD</i>				DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>6/16/81</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. Edwin Pierpont</i>				22e. ADDRESS <i>8204 Liberty Road Balto. MD. 21207</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>6/19/81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Crematory</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City, Maryland</i>		
24. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, P.A. 8728 Liberty Road Randallstown, MD. 21133</i>				25a. DATE REG'D. BY REGISTRAR <i>JUN 18 1981</i>		25b. REGISTRAR'S SIGNATURE <i>Loring Byers</i>		

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ORIGINAL MINUTES

11-10-103 5:00

11/10/103

11/10/103

11/10/103

11/10/103

11/10/103

Copy of Minutes from 11/10/103  
11/10/103  
11/10/103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 1 4 8 0 4	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>DORA Thorne MORRIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>6 26 81</b>		2b. HOUR <b>4:35 P.M.</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 12 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Pikesville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE FULL NAME AND STREET ADDRESS) <b>Pikesville Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Rosedale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Kemper Horton</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Alice Jones</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-46-8847</b>		17. INFORMANT ADDRESS <b>Joan A. Gresdo 8011 Camhill Drive 21237</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
7140 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Spinal Cord Injury</b>					<b>6-8 mos-</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atypical Arteriosclerosis 2° Rheumatoid Arthritis</b>					<b>Years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Aspirin</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>6/21 19 78</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6/17 19 81</b> to <b>6/26 19 81</b> , that (I) (we) last saw the deceased alive on <b>6/17 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we, did not view the body after death.)					
22b. SIGNATURE <b>Harold B. Bob M.D.</b>		22c. DATE SIGNED <b>6/29/81</b>		22d. ADDRESS <b>7220 Park Heights Avenue</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6-29-81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>7225 Eastern Blvd. Balto., Md.</b>		24. FUNERAL DIRECTOR NAME <b>C.S. Zeiler &amp; Son Inc. 6224 Eastern Ave. 21224</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 30 1981</b>	
25b. REGISTRAR'S SIGNATURE <b>Petryk habrudy</b>					

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Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		8114805					
1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE T. MOSMILLER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>JUNE 1 1981</b>		2b. HOUR <b>7:30A</b> M			
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7/9/18</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY</b> MD.			
10 CITY OR TOWN OF DEATH <b>ESSEX</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>910 N. MARLYN AVE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HSWE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>				13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>ESSEX</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM PETRI</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>IDA REED</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>UNK</b>		17 INFORMANT ADDRESS <b>CATHERINE BRUMMETT ABOVE</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIOVASCULAR</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>SUDDEN DEATH</b> <b>24 YEARS</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 19 49</b> to <b>JUNE 1 19 81</b> , that (I) (we) last saw the deceased alive on <b>APRIL 27 19 81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Joseph Miceli M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>6/2/81</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOSEPH MICELI, M.D.</b>				22e. ADDRESS <b>108 S. TAYLOR AVE ESSEX, MD. 21221</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>6/4/81</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO. MD.</b>			
24 FUNERAL DIRECTOR NAME <b>J.G. CONNELLY</b>				ADDRESS <b>300 MACE</b>		25a. DATE REC'D. BY REGISTRAR <b>JUN 9 1981</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

